REPORT RESUMES

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RC 001 831

FLORIDA MIGRANT HEALTH PROJECT. FOURTH ANNUAL PROGRESS REPORT, 1966-1967.

FLORIDA ST. BOARD OF HEALTH, JACKSONVILLE

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DESCRIPTORS- *MIGRANT HEALTH SERVICES, *ACTIVITIES, *MIGRANT WORKER PROJECTS, *CLINICS, *MEDICAL SERVICES, MIGRANTS, PERSONNEL, REFERRAL, DENTAL CLINICS, VISION TESTS, NURSING, MIGRANT HOUSING, HEALTH EDUCATION, DISEASES, CONFERENCES, FLORIDA MIGRANT HEALTH PROJECT, U. S. PUBLIC HEALTH SERVICE,

THE FOURTH ANNUAL PROGRESS REPORT OF THE FLORIDA MIGRANT HEALTH PROJECT INDICATES THAT IN 1966-67 THERE WAS AN APPRECIABLE INCREASE IN THE AMOUNT AND VARIETY OF MIGRANT HEALTH SERVICES RENDERED, THE NUMBER OF MIGRANTS CONTACTED, AND THE ACTIVITIES PERFORMED BY PROJECT PERSONNEL. MIGRANT HEALTH SERVICE REFERRALS INCREASED BY 1,222 OVER THE SAME PERIOD THE PREVIOUS YEAR. THE NUMBER OF MEDICAL CLINICS INCREASED, PROVIDING SUCH SERVICES AS DENTAL CLINICS, VISION TESTS, MEDICAL SERVICES, NURSING, AND DIABETES SCREENING. SOME ADVANCES WERE MADE IN IMPROVED MIGRANT HOUSING AND HEALTH EDUCATION ACTIVITIES. PLANS FOR THE FUTURE CALL FOR AN INTENSIVE VENEREAL DISEASE PROGRAM, INPATIENT HOSPITAL CARE, RESUMPTION OF VISION, DENTAL, AND DIABETES SCREENING, ADDITIONAL MEDICAL AND DENTAL CLINICS, AND HOLDING A MIGRANT HEALTH SERVICES CONFERENCE. (JS)

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Florida Migrant Health Project

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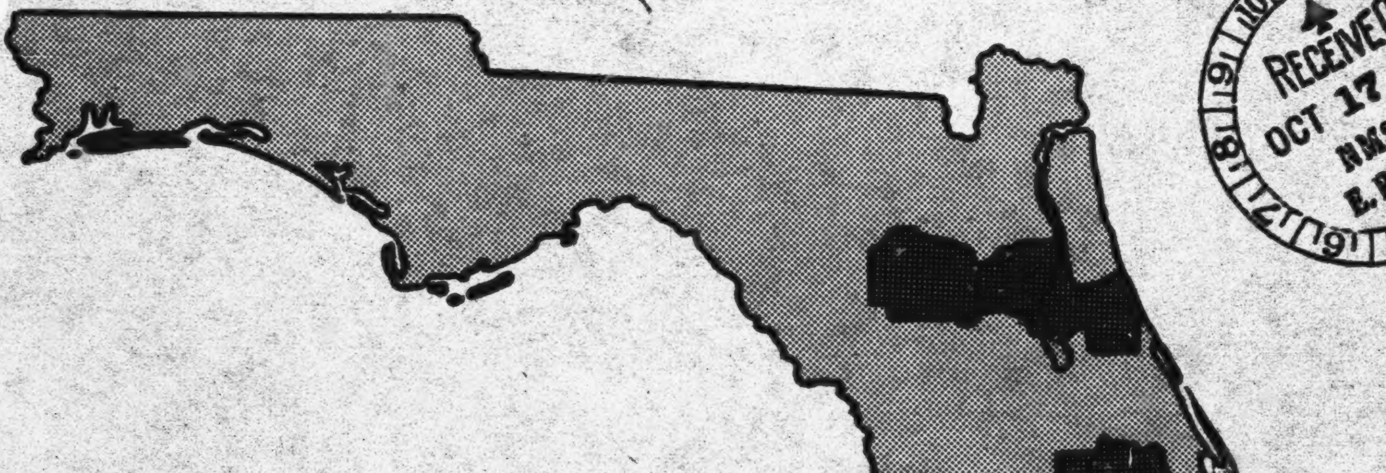

Fourth Annual Progress Report 1966 - 1967

Florida State Board of Health
in cooperation with the
U.S. Public Health Service

RC 001 831

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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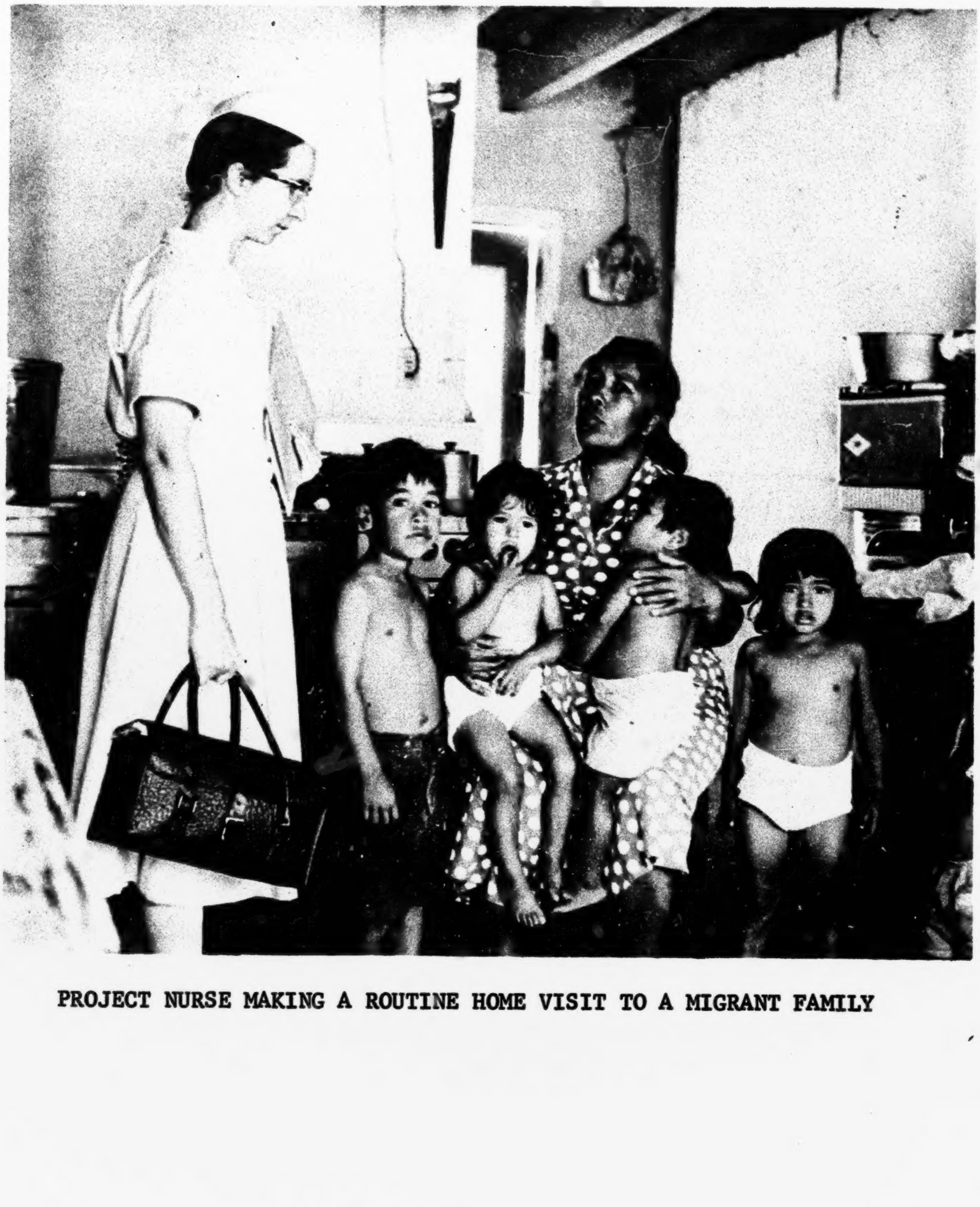
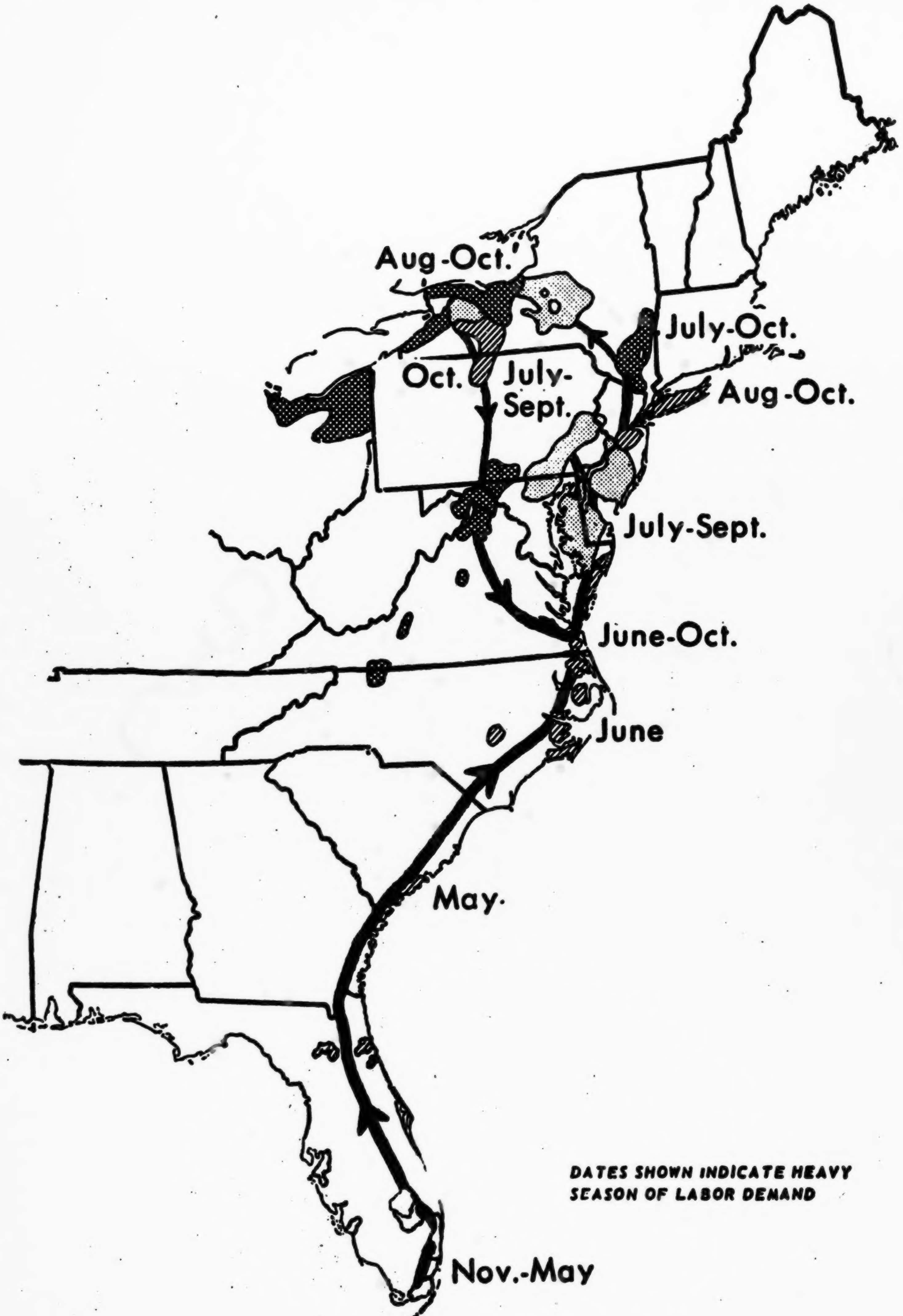
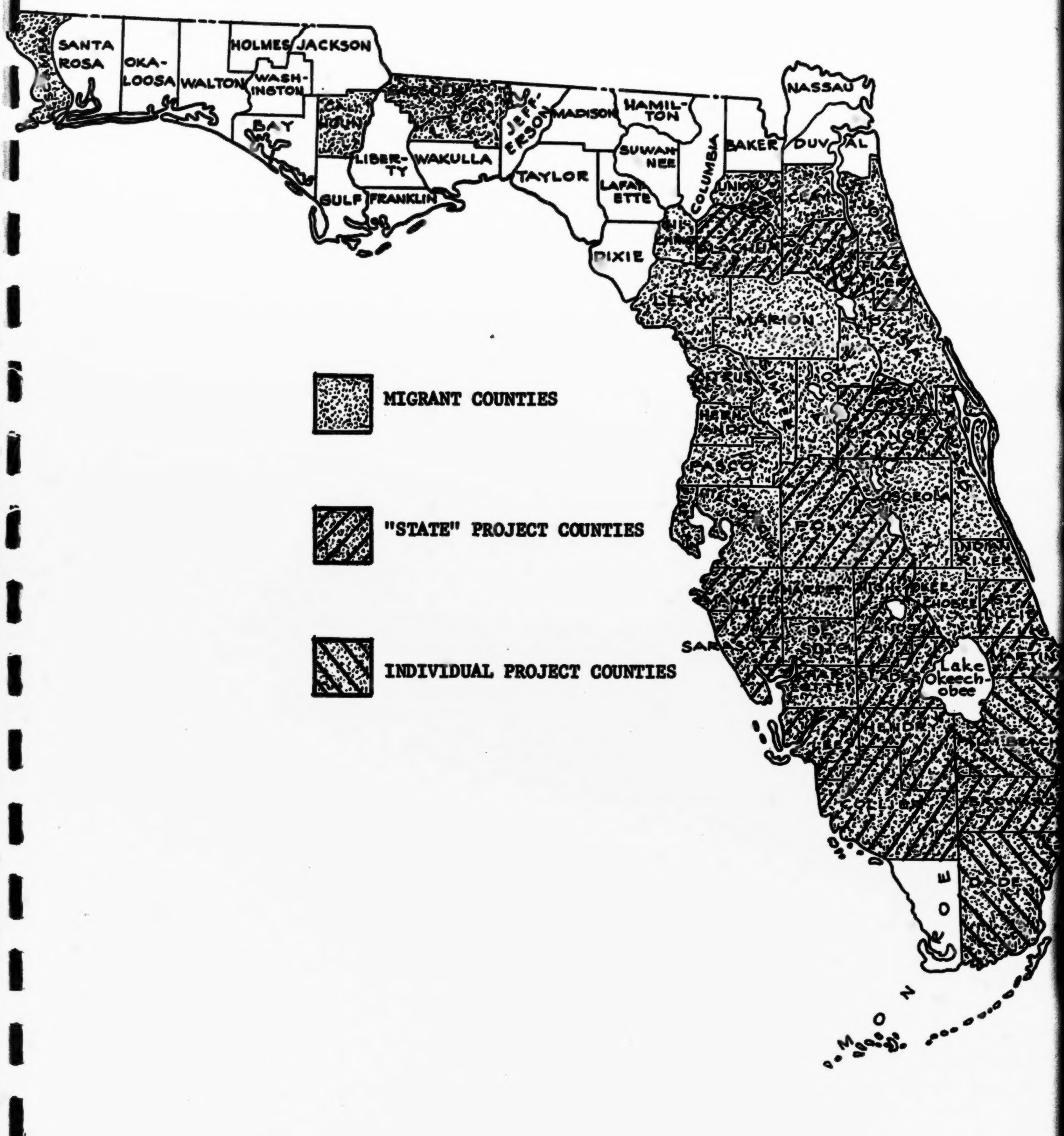


PROJECT NURSE MAKING A ROUTINE HOME VISIT TO A MIGRANT FAMILY


Aug-Oct.
July-Oct.
Oct.
July-Sept.
Aug-Oct.
July-Sept.
June-Oct.
June
May
Nov.-May
DATES SHOWN INDICATE HEAVY SEASON OF LABOR DEMAND

THE ATLANTIC COAST MIGRATORY STREAM.

STATE OF FLORIDA


MIGRANT COUNTIES
"STATE" PROJECT COUNTIES
INDIVIDUAL PROJECT COUNTIES
SANTA ROSA
OKA-LOOSA
WALTON
HOLMES
JACKSON
WASH-INGTON
BAY
CAL-HOUN
LIBER-TY
WAKULLA
GULF
FRANKLIN
JEFF-ERSON
MADISON
HAMIL-TON
SUWAN-NEE
TAYLOR
LAFAY-ETTE
DIXIE
COLUMBIA
BAKER
NASSAU
DUVAL
MARION
PASCO
POLK
OSCEOLA
INDIAN RIVER
HARDEE
SARASOTA
DE SOTO
Lake Okeech-obee
MONROE

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FLORIDA STATE BOARD OF HEALTH

ANNUAL PROGRESS REPORT

MIGRANT HEALTH GRANT MG-18D (67)

PREFACE

This is the Fourth Annual Progress Report on the Migrant Health Program in Florida, to be submitted to the United States Public Health Service.

Migrant health activities carried on by seventeen (17) of the eighteen (18) Florida county health departments who are recipients of Federal grants for this purpose from the United States Public Health Service are detailed in the following pages. In the main, the period covered by the individual reports of these counties extends from May 1, 1966, through April 30, 1967.

For purposes of clarification, it might be appropriate to mention that heretofore the annual project reports published by the Florida State Board of Health were limited to the inclusion of migrant health services provided by those county health departments participating in the Florida "State" Migrant Health Project. The term "State" was employed to differentiate between the multiple-county project and the two (2) separate projects of Palm Beach and Dade counties. These two (2) counties are funded by the United States Public Health Service on an individual basis and the administration of their projects is vested in their respective county health officials. This current annual report comprises the reports of the sixteen (16) counties of the "State" or multiple-county project, plus that of Dade County. The word "project" when used in subsequent pages of this report (with the exception of the individual county report sections) refers exclusively to the "State" project.

The "State" project is administered by the Bureau of Maternal and Child Health of the Florida State Board of Health. The Bureau Director is E. Henry King, M.D.; the Migrant Health Coordinator is William J. Clarke, Jr.

ANNUAL PROGRESS REPORT

MIGRANT PROJECT HISTORY

The Florida State Board of Health initially received a grant award from the United States Public Health Service in 1963 to inaugurate a migrant project entitled: "A project to develop a basic statewide program of health services for migrant farm workers and their dependents in Florida." This title was retained for the second and third years' operation of the project. The title was slightly modified for the fourth year's operation by dropping the word "basic" as it was felt that the project had progressed in many ways by then past the fundamental point and was reaching for the attainment of a more complete status. The first year's operation might be considered as a "planning" year during which information necessary to implement the following year's "action" program was gathered. The project period for the first year extended from September 1, 1963, through August 31, 1964. The First Annual Report covered this twelve (12) month period.

The United States Public Health Service approved Florida's Project Continuation Request and the second or "action" year of the project started in September of 1964. Ten (10) counties comprised the nucleus of the "State" project during the first few months of the second year's operation, but a subsequent Project Revision made is possible for three (3) additional counties to participate and to extend the project period through the calendar year 1965.

Florida's second Project Continuation Request was tentatively approved (subject to some budget revisions) by the United States Public Health Service in the late fall of 1965. The necessary Budget Revisions were later submitted and approved in January of 1966, with the project year designated as February 1, 1966, through December 31, 1966. During this period an additional county joined the project, thereby increasing the total number of counties participating to fourteen (14).

An Application for a Project Renewal to take effect on January 1, 1967, was submitted by the Florida State Board of Health during the summer of 1966 and a subsequent Budget Revision was submitted in the fall. The 1966 grant period was extended by the United States Public Health Service through February, 1967, with the present (1967) grant period to be in effect from March 1, 1967, through December 31, 1967. This action, extending the grant period through two additional months, necessitated the submission of an additional Budget Revision.

ANNUAL REPORT

FLORIDA STATE MIGRANT HEALTH PROJECT

Migrant Situation

During the 1966-67 agricultural season, migrant workers began arriving during the latter part of August, 1966. On August 31, 1966, there was an estimated seasonal employment of 21,857, of which 20,430 were local; 480 were foregin, and 947 were from other areas or other states. About 46 per cent of the employment was concentrated in citrus preharvest and harvest. The small number of foreign workers reported at that time were located in the Lake Okeechobee area and were used to cut sugarcane for replanting.

By November 15, seasonal agricultural employment had increased to 54,883 workers. Central Florida citrus harvest for fresh pack, South Florida vegetable harvest and sugarcane harvest for mill operations were all underway. Around 9,700 workers from other Florida areas and other states were now employed in seasonal agricultural activities. About 7,000 foreign workers were engaged in sugarcane operations in the Lake Okeechobee area.

Employment reached peak level on January 31, 1967 with an estimated 79,856 workers. At this time there were approximately 30,600 workers in citrus harvest and grove care, and 9,600 in sugarcane. About 8,400 of the sugarcane workers were from the British West Indies. The ethnic composition of the domestic work force was estimated to be: Anglo, 17 per cent; Texas-Mexican, 15 per cent; Negro, 58 per cent; Puerto Rican, 10 per cent. The Anglo group of workers increased during the past year due to integrated housing being available in all areas and due to the lack of Negro workers. Other opportunities and programs which were developed last year competed for the use of Negro agricultural seasonal workers.

Although tight labor conditions were reported from time to time, no serious shortages occurred until May of 1967. The citrus crop had been late in maturing and many migrant workers began moving on to other job commitments during the temporary lull between early and mid season fruit and the Valencia harvest. Growers attempted to keep workers busy with grapefruit harvest and irrigation work, but in spite of this, substantial numbers of migrant workers left the area. The situation was alleviated by the arrival of approximately 1,600 foreign workers from the British West Indies on May 31, 1967. By June 15, 1967, this number had increased to a total of 2,900 foreign citrus pickers. It is expected that citrus harvest operations will be virtually completed by July 15, 1967, and that the foreign workers will have departed.

Mechanization increased during the 1966-67 season. More growers began using the mechanical harvester for celery. Recruitment for celery cutters has always been difficult and no workers have been displaced. Celery cutters are now being used for the stripping operations. Use of bean harvesters is becoming more widespread. Most growers used the available labor for the first picking of this crop and used the machines for the second picking. Harvesting of potatoes has become almost entirely mechanized. Tung nut harvesting by machine was successful on a large scale for the first time last year, cutting hand labor by about 65 per cent. Machines have reduced hand labor for stringing tobacco leaves by about 25 per cent. Citrus grove care is becoming more mechanized with the use of new and improved machines.

It is not anticipated that the number of workers needed for the 1967-68 season will vary significantly from the current growing season. Citrus acreage is increasing, particularly in South Florida; however, indications are that the crop may be somewhat lighter next year due to the drought in the spring. Increased acreage in vegetable crops will be offset by increased mechanization.

Migrant workers begin leaving Florida during May with heavy migration during June after school terms have been completed. Around 40,000 to 45,000 workers and their families are expected to leave Florida this year. First destinations for most migrants after leaving Florida are in the east coast sections of South Carolina, North Carolina, and Virginia. The migrant stream continues up the eastern seaboard states after June 15, to Pennsylvania, Maryland, New Jersey, and into New York after July 1. The eastern seaboard pattern states' agricultural harvest continues active into September and October when many Florida-based crews are used in apple harvest in Virginia and New York and in the late fall vegetable harvest in North and South Carolina and Virginia. We also have a significant migrant pattern to the midwestern states of Ohio, Indiana, and Michigan. This pattern has grown rapidly during the last five years with a total estimated migrant work force from Florida of approximately 8,500 workers. This pattern begins in July with vegetables and cherries and is completed in September with the Michigan apple harvest.

MIGRANT HEALTH SERVICE REFERRAL SYSTEM

During the year covered by this report, public health workers in the ten participant states were asked to comment on their experiences in using the Referral System and to offer suggestions toward its further development.

A survey of 120 public health workers in the participant states resulted in valuable suggestions based upon actual use of the system. Suggested revisions were incorporated into a prototype referral form which was circulated among participant states for review. Reactions were favorable. Plans are to produce the final version of the Referral form after appropriate administrative clearances have been obtained.

Each of the ten health service indexes, one for each participant state, are to be combined into one volume which, hopefully, will be easier to use than the present system. However, there are difficulties in obtaining funds for this undertaking and the money problem is yet unresolved.

An additional state, West Virginia, has asked to be included in the Referral System. Therefore, a West Virginia Health Service Index is under development.

Review of referrals as they are returned to this office indicate that the system continues to function reasonably well. Over half of the patients thus referred receive direct health services in areas to which they are referred.

Experience at this point suggests strongly that the system works well where plans for health service continuity are discussed with migrant patients by public health personnel as soon as practical following initial service contact.

The system has been well tested during the past several years. Public health officials in the ten participant states have endorsed its use. There is need to continue interest and effort toward wider use at local levels.

It is apparent that local effort and interest were strengthened this reporting year over that of last year when one considers the fact that 1,763 referrals were completed this year, compared with a total of 541 during last year - an increase of 1,222.

1372

MIGRANT HEALTH SERVICE REFERRAL

Referred from: 2 | 3 | 4 | 1 | 3
Col. 1 2 3 4 5

Patient name: Johnson Dock
last first middle

Col. 6 Male ☒ Female ☐
Col. 7 Under 1 yr. old ☐
Col. 8 9 Age in years 6 | 6

Col. 10 Negro ☒ 1 Col. 10 Spanish ☐ 2 Col. 10 Anglo ☐ 3 Col. 10 Other ☐ 4

Service Request:

Col.		PREVENTIVE
11		cancer cytology
12		chest x-ray
13		child spacing
14	✓	health appraisal
15		immunizations
16		nutrition
17		postpartum
18		prenatal

		CURATIVE
19		diabetes
20		intest. parasite
21		rheumatic fever
22		tuberculosis
23		venereal disease
24		V.N.A.

		REHABILITATIVE
25		crippled child.
26		vocational

Health Service Instructions: Seen at mobile cl- 6-16-66 for Hypertrophic Arthritis Rx ASA & heat

Patient Location Information: C. L. B. T. Lewis 428½ N.W. 6th ave Pompano Beach Fla. Pt going to 412 N.W. 6th St. apt. Bldg. will work for K. D. Eaton crew 9-15.

Col. 27 28 29 30 31 Referred to: 3 | 3 | 0 | 6 | 0

Col. 32 33 34 Date: 0 | 9 | 6
Mo. Yr.

Authorized signature: Dorothy A. Durlon PHN

PLEASE NOTE: Upon provision of service requested or after 60 days following receipt of referral, please complete REFERRAL EVALUATION (below), fold so that the referral will be sent to FLORIDA STATE BOARD OF HEALTH. The reverse side of this sheet is already addressed. Postage is guaranteed.

REFERRAL EVALUATION

Please mark all items which apply:

Col.		
35		Request for service was provided
	☐	1. Partially
	☒	2. Completely
36	☐	Requested service was not provided
37	☐	Patient sought service requested
38	☒	Patient was sought out by PHP*
39	☐	Unable to locate patient

*Public Health Personnel

Comments: Seen by Dr. Burry at Migrant Clinic Rx given for arthritis and Hypertension - assistance in obtaining S.S. benefits as he is unable to work.

Authorized signature: Elsie Sweetzer

Col. 40 41 42 Date: 1 | 0 | 6
Mo. Yr.

A completed Migrant Health Service Referral Form which originated in Virginia and was sent to Florida to assure further service to the patient. The referral system is designed to provide continuity of health care as migrants move from place to place.

ANNUAL PROGRESS REPORT

PROJECT OBJECTIVES FOR 1967

(1) TO INCREASE THE AMOUNT AND SCOPE OF HEALTH SERVICES OFFERED TO MIGRANTS, ESPECIALLY IN THE FIELDS OF MEDICINE AND DENTISTRY.

To date this objective has been met, especially as far as the medical aspect is concerned. Additional medical and nursing clinics were opened by some of the counties during this report period and the dental facet of the objective was also strengthened. The number of patients receiving services increased during this report period over that of last year, in some instances up to 400 per cent. The following tables from a few of the county reports illustrate the substantial increase in services rendered:

BROWARD COUNTY	1966	1967
Medical Clinic Attendance	2785	3574
Dental Clinic Attendance	119	511
Nurse Field Visits	590	818

GLADES-HENDRY COUNTIES	1966	1967
No. Clinics Held	258	317
No. Patients Seen at Clinics	1232	2832

LEE COUNTY	1966	1967
No. Doctors' Clinics	46	79
No. Nurses' Clinics	229	276
No. Patients Seen by Doctors	1119	1566
No. Patients Seen by Nurses	2076	5162

ORANGE COUNTY	1966	1967
No. Patients Seen at Clinics	2380	3310
No. Physician Services to Patients	1767	2871
No. Nurses Services to Patients	2380	9345

The scope of health services rendered was broadened with the initiation of Intrauterine Devices (IUD's) and dermatology clinics.

In addition to this, certain plans contained in last year's Annual Report under the title Future Plans were implemented and proved to be of benefit to both migrant patients and project personnel. These plans included vision screening by an Orthoptist, diabetes screening by project personnel after instruction by a Diabetes Control Program Coordinator, and dental screening by a Dental Hygienist. The three "specialists" involved are employed by the Florida State Board of Health, and although not connected with the Migrant Project, devoted many hours to working with the migrants in various project counties.

It is anticipated that the upward swing in services rendered during this project year will continue due to the increased number of dependents who are remaining in Florida while the breadwinners migrate and also to the anticipated opening of proposed medical and dental clinics in St. Lucie and Martin counties.

(2) TO INCREASE THE HEALTH EDUCATION ACTIVITIES OFFERED TO MIGRANTS.

The success or failure in meeting this objective would be difficult to assess or measure with any degree of accuracy. It is felt that the objective has been met partially, at least, because more migrants have come into contact with project personnel as depicted in the foregoing tables. This contact would consequently result in more health education activity directed to the migrants from the public health personnel. The position of health educator on the project has remained vacant up to the present, although it is anticipated that it will be filled by the first of July. The failure to fill this position due to the lack of qualified applicants, has been detrimental to efforts to achieve this particular objective. Guidance from a professional health educator is necessary to stimulate education activities in the counties, and although some project counties have made progress on their own in this direction (as stated in their reports), much remains to be done by year's end.

(3) TO INCREASE THE NUMBER OF MIGRANT HEALTH SERVICE REFERRALS MADE AND THE NUMBER OF PERSONAL HEALTH RECORDS (PHS - 3652) GIVEN.

This objective has been met as there has been an increase in the number of referrals made and records given during this reporting period over the same period last year.

Referrals completed during the previous report period numbered 541, while those completed during the present report period totaled 1222 - a significant increase.

(4) TO INCREASE THE NUMBER OF COUNTIES PARTICIPATING IN THE HEALTH SERVICE REFERRAL FORM SYSTEM AND IN THE MIGRANT PROJECT.

To date there has been no increase in the number of Florida counties participating in the Referral Form System. It is expected that counties hosting migrants in West Virginia will begin participation this summer. There has been an increase in the number of Florida counties receiving and processing both intrastate and interstate referrals, although these counties are not presently listed in the Florida Referral Index. It is planned, however, to include them in the proposed new Index, thus increasing the number of counties officially participating. The number of counties participating in the Migrant Project has been increased from fourteen (14) to sixteen (16), with the advent of St. Lucie and Martin.

(5) TO INCREASE THE AMOUNT OF INFORMATION RELATING TO THE MIGRANT PROJECT DISSEMINATED TO THE PUBLIC.

This objective has been met although it would be difficult to document it in detail. Project personnel this year have made more talks to audiences of lay and professional people, released more newspaper articles, and appeared on more television and radio programs than during any report period since the inception of the project.

NUTRITION SERVICES

to the

MIGRANT HEALTH PROJECT

Increased nutrition services have been provided to migrant agricultural workers during the past year. Particular emphasis has been given by the nutritionist assigned to serve Lee and Collier Counties and the nutritionist working in Highlands, Glades and Hendry Counties. These nutritionists have provided diet counseling services in clinics to maternity patients, helped mothers with child feeding, and given dietary guidance to persons with diabetes, weight problems, heart conditions, and other disorders for which physicians have prescribed therapeutic diets. Nutritionists have made some visits to the camps and homes where migrant agricultural workers live with their families to provide diet counseling and to better understand the limited living conditions under which meals must be prepared and served. Some talks and demonstrations were presented in schools and to parents, migrant aides, and public health personnel to help them understand food and nutrition needs. Nutritionists have cooperated with home economists in other agencies such as Agriculture Extension or Community Action Programs on behalf of migrant families. Regional nutritional consultants rendered some diet counseling services in Seminole, Putnam and Flagler Counties and in these and other project counties gave consultation and inservice education to health department staff. During this year three graduate nutrition students in public health, in Florida for field experience, were given orientation and an opportunity to observe the migrant health program in some of the counties.

The resignation in December of the Regional Nutrition Consultant who served as Nutrition Coordinator for the Statewide Migrant Health Project caused a setback in development and full implementation of a coordinated program plan for nutrition services to the migrant agricultural workers and their families. During the year of this report, the Nutrition Coordinator was actually on duty for only three months since she had taken leave without pay for three summer months to work on a special migrant project in New York State. Since this regional nutritionist also was responsible for services to Polk, Manatee, and Sarasota Counties, these counties in the statewide migrant project had no available service from a nutritionist for most of the year. The Director of the Division of Nutrition has spent considerable effort in recruiting a qualified nutritionist for this position but a salary level not competitive with other states recruiting nutritionists has been a handicap.

Although nutrition education materials used with low income families in the overall nutrition program have been used with families of migrant agricultural workers, it has been felt that some materials prepared around their special needs might be more effective. Through correspondence with nutritionists in other states, nutrition teaching materials being used in other programs are being obtained and reviewed for content and approaches which might be used in Florida. A set of slides with narrative was prepared and has been used for group meetings and for public health staff education. Four kits of equipment for food demonstrations have been purchased with migrant project funds and have been put into the field for nutritionists to use to teach proper and easy methods to prepare nutritious foods. Work is being done on some simple leaflets to be prepared both in English and Spanish. Nutritionists participated in the Statewide Migrant Health Conference in Miami Beach and the Director of the Division of Nutrition spoke on the dietary deficiencies, problems, and needs in nutrition of the migrant agricultural workers and their families.

As nutritionists work with the migrant agricultural workers, they learn more about their food habits, living conditions, values, ethnic backgrounds, and needs in nutrition education. It is hoped that the project position can be filled soon so that activities can be better coordinated, a more systematic study can be made of nutritional needs, and problems and more services can be rendered during the coming year.

MIGRANT HEALTH PROJECT

DIABETES SCREENING PROGRAM

During the period covered by this Annual Progress Report, the Florida State Board of Health representative of the Diabetes Control Program made twenty (20) on-site field visits to Orange, Seminole, Broward, Dade, Collier, Lee, Hendry, Sarasota, Manatee, and Polk counties.

During these visits he trained the Migrant Project nurses in the techniques of computing dietary data, conducting Dextrostix testing, and interpreting the results in conjunction with the dietary data. He explained the coding of diabetes activities and stressed the importance of follow-up of every suspect until he/she is diagnosed and (if indicated) treated.

Rapport between this state program, the Division of Nutrition, and the county migrant physician, nurses, and supportive personnel appears to be excellent at this time.

Additional information regarding diabetic screening may be found in the reports from the various counties which are included in a later section of the report.

MIGRANT HEALTH PROJECT - DENTAL SCREENING PROGRAM

In order to determine the extent of the dental needs of migrant workers and their dependents, a dental hygienist on loan from the Bureau of Dental Health made a survey of 1,673 children and adults in nine counties.

Eighty per cent (80%) of this group (1,339) were found to be in need of dental care. A record was made of the types and amounts of dental care needed by the migrants and will be available for use in further planning and development of the dental program for this group.

The dental survey revealed that the typical migrant family is in need of rather extensive dental care.

RESULTS OF DENTAL SURVEY IN NINE PROJECT COUNTIES

COUNTY	NUMBER GIVEN DENTAL INSPECTIONS	NUMBER IN NEED OF DENTAL CARE
Seminole		
Negro - Adults	29	25
Negro - Children	218	185
White - Children	10	8
Broward		
Negro - Adults	21	18
Negro - Children	266 (229 Sn_2F Treatments)	217
Puerto Rican	35	31
Collier		
Negro - Adults	5	3
White - Adults	5	4
Mexican - Adults	29	25
Mexican - Children	562	423
Lee		
Negro - Adults & Children	62	54
Puerto Rican - Adults & Child.	44	33
Mexican - Adults	11	8
Hendry		
Mexican - Adults & Children	26	19
Glades		
Negro - Adults & Children	16	13
Manatee		
Negro - Adults & Children	89	83
Mexican - Adults & Children	13	11
Sarasota		
Negro - Adults & Children	44	34
Mexican - Adults & Children	54	38

COUNTY	NUMBER GIVEN DENTAL INSPECTIONS	NUMBER IN NEED OF DENTAL CARE
Polk		
Negro - Adults & Children	118	97
Mexican - Adults & Children	16	10
TOTAL	1,673	1,339 (80%)

SUMMARY OF DENTAL SURVEY OF MIGRANTS BY ETHNIC GROUPS

ETHNIC GROUP	NO. INSPECTED	NUMBER IN NEED OF DENTAL CARE
Negro	868	729
Mexican	711	534
Puerto Rican	79	64
White	15	12
TOTAL	1,673	1,339 (80%)

MIGRANT HEALTH PROJECT

VISION SCREENING PROGRAM

During the report period a certified Orthoptist, employed by the Florida State Board of Health, carried on an abbreviated vision screening program in three Migrant Project counties - Broward, Lee, and Seminole. Testing was performed at night migrant clinics.

In Broward County, eight migrants (ranging in age from 6 to 64 years) were tested and none were found to have vision acuity of less than 20/40. Twenty migrants in Lee County (ranging in age from 7 to 60 years) were tested with six being found to have visual acuity of less than 20/40, and one having extremely poor muscle balance. One of the migrants tested was a Texas-Mexican boy, 16 years old, who was a fourth grade pupil. In Seminole County 34 migrants (ranging in age from 5 to 67 years) were tested with one having a visual acuity of less than 20/40, and four afflicted with excessive farsightedness.

It is planned to conduct vision screening on migrants in additional project counties during 1967. Failures will be referred to Optometrists or Ophthalmologists - or in the case of school children - to the school system.

GENERAL SANITATION EXHIBITS

In the Sanitation Section of many of the county reports, reference is made to Chapter 170C-32 of the Sanitary Code of Florida, House Bill No. 269, and the Camp Inspection Form. For the purpose of eliminating duplication, these materials (concerned with migrant camps) are reproduced on the following 13 pages.

RULES OF THE STATE BOARD OF HEALTH

THE SANITARY CODE OF FLORIDA

CHAPTER 170C-32

CAMPS

170C-32.01	Camps - general (381.031(1)(g)3.F.S.)
170C-32.02	Definitions (381.031(1)(g)3.F.S.)
170C-32.03	Notice of construction (381.031(1)(g)3.F.S.)
170C-32.04	Permit for operation (381.031(1)(g)3.F.S.)
170C-32.05	Application and issuance of permit (381.031(1)(g)3.F.S.)
170C-32.06	Revocation of permit (381.031(1)(g)3.F.S.)
170C-32.07	Camp sites (381.031(1)(g)3.F.S.)
170C-32.08	Shelters (381.031(1)(g)3.F.S.)
170C-32.09	Water Supply (381.031)(1)(g)3.F.S.)
170C-32.10	Garbage and refuse disposal (381.031)(1)(g)3.F.S.)
170C-32.11	Insect and rodent control (381.031(1)(g)3.F.S.)
170C-32.12	Heating (381.031(1)(g)3.F.S.)
170C-32.13	Lighting (381.031(1)(g)3.F.S.)
170C-32.14	Excreta and liquid waste disposal (381.031(1)(g)3.F.S.)
170C-32.15	Plumbing (381.031(1)(g)3.F.S.)
170C-32.16	Toilets (381.031(1)(g)3.F.S.)
170C-32.17	Washrooms, bathrooms and laundry tubs (381.031(1)(g)3.F.S.)
170C-32.18	Food service facilities (381.031(1)(g)3.F.S.)
170C-32.19	Beds and bedding (381.031(1)(g)3.F.S.)
170C-32.20	Fire protection (381.031(1)(g)3.F.S.)
170C-32.21	Sanitary maintenance of premises (381.031(1)(g)3.F.S.)
170C-32.22	Responsibility of camp operator (381.031(1)(g)3.F.S.)
170C-32.23	Camp supervision (381.031(1)(g)3.F.S.)
170C-32.24	Responsibility of occupants (381.031(1)(g)3.F.S.)

170C-32.01 Camps - general - Sanitary practices relating to construction, operation and maintenance of migrant labor, recreation and other camps. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.422-.482 FS)

170C-32.02 Definitions - (1) "Camp" - One or more buildings or structures, tents, trailers or vehicles, together with the land appertaining thereto used as living quarters for fifteen (15) or more persons, including children, whether or not rent is paid or reserved in connection with the use or occupancy of such premises. Included are camps operated for recreational, educational and other purposes and labor camps established for the permanent or temporary housing of farm laborers or other workers; provided, that this definition shall not apply to forestry or tobacco farm operation.

(2) "Person" - An individual or group of individuals, association, partnership or corporation.

(3) "Camp operator" - The person who has been granted a permit in

accordance with these regulations to operate a camp.

(4) "Shelter" - Any building of one or more rooms or tents or trailers used for sleeping or living quarters at a camp.

(5) "Habitable room" - A room or enclosed floor space used or intended to be used at a camp for living, sleeping, cooking or eating purposes excluding bathrooms, water closet compartments, laundries, pantries, foyers, connecting corridors, closets or other storage space.

(6) "Toilet facilities" - Water closets, privies, urinals and the rooms provided for the installation of these units.

(7) "Refuse" - Solid waste except body wastes, including garbage, rubbish and ashes.

(8) "Garbage" - Waste products of all animal or vegetable matter resulting from growing, processing, marketing and preparation of food items, including containers in which packaged.

(9) "Sanitary landfill" - A planned method of compacting and completely covering garbage in a prepared area so as to prevent sanitary nuisances and insect and rodent breeding and harborage.
(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.422. FS)

170C-32.03 Notice of construction - Each person who is planning to construct or enlarge for occupancy or use a camp or any portion of facility thereof, or to convert a property for use or occupancy as a camp shall give notice in writing of his intent to do so to the board at least fifteen (15) days before the date of beginning such construction, enlargement or conversion. The notice shall give the name of the city, village, town or county in which the property is located, the location of the property within that area, a brief description of the proposed construction, enlargement or conversion and the name and mail address of the person giving the notice and his telephone number, if any. Upon receipt of such notice the board shall send promptly to the person giving notice copies of the state law and regulations issued thereunder applicable to camps. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 381.472. FS

170C-32.04 Permit for operation - Before any person shall either directly or indirectly operate a camp he shall make an application for and receive from the board a valid permit for operation of the camp. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) s FS, 381.432 FS)

170C-32.05 Application and issuance of permit - Application for such permit shall be made in writing to the board through the local health department on a form provided for this purpose at least fifteen (15) days prior to commencement of camp operation. The application shall include the name and address of the camp owner, name and address of the person requesting a permit to operate the camp, the location of the camp, the approximate period during which the camp is to be operated and such other pertinent information as the board shall find necessary. A separate application shall be submitted for each camp and a separate permit shall be issued annually for each such camp. If the board finds after investigation that the camp or proposed operation thereof conforms or will conform to the minimum standards required by these regulations, they shall issue a permit for operation of the camp. The permit, unless sooner revoked, shall expire on June 30 next after the date of issuance. The permit shall not be transferralbe or assignable. In the event of a change of operator of a camp, the new operator shall immediately file an application for permit in accordance with provisions of this section.

(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.442 FS; 381.452 FS)

170C-32.06 Revocation of permit - A permit may be revoked at any time if the board finds the camp for which the permit is issued is maintained, occupied or operated in violation of law or any regulations applicable to a camp or in violation of a condition stated on the permit. In case of a revocation of permit the camp operator may make application for a new permit by complying with the provisions of Section 170C-32.05 of this chapter. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.462 FS)

170C-32.07 Camp sites - (1) All camp sites shall be well drained and free from depressions in which water may stand. No camp shall be located in or immediately adjacent to marshes, bottom lands, or other potential mosquito breeding areas unless adequate board approved safeguards or preventative measures are taken. Natural sink holes, swamps, pools or other surface collectors of water within two hundred (200) feet of the periphery of the camp shall either be drained or filled to remove quiescent surface water except that such areas containing water not subject to such drainage or filling shall be treated with oil or other larvacide as necessary to prevent the breeding of mosquitoes.

(2) No camp shall be located on a site which is subject to or may cause extreme traffic or other hazards unless acceptable safeguards are provided.

(3) No camp shall be located on the watershed of a domestic or public water supply so as to create a pollution hazard.

(4) No camp structure shall be located less than two-hundred (200) feet from barns, pens or similar quarters of livestock or poultry.

(5) All camp sites shall be adequate in size to permit locating of buildings so as to minimize the hazards of fire.

(6) All camps shall provide space for recreation commensurate with the purpose of the camp, the size of the camp and the type of occupancy. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.08 Shelters - (1) Shelters in all camps shall be structurally sound and shall provide protection to the occupants against the elements. At least one-half (½) of the floor area of each habitable room shall have a minimum ceiling height of seven (7) feet. Floors of the buildings used as living quarters shall be constructed of wood, concrete or other comparable material. Wooden floors shall be of tight durable construction with a smooth finish and in buildings without a cellar or basement, shall be elevated not less than eighteen (18) inches above the average ground level to permit free circulation of air.

(2) All concrete floors shall be smooth finished and the floor level shall be not less than twelve (12) inches above the average ground level.

(3) All rooms designed or used for sleeping purposes shall provide a minimum of three-hundred (300) cubic feet of air space for each occupant. In computing the cubic footage of sleeping rooms, ceiling heights shall be counted to a maximum of nine (9) feet and no floor area shall be counted where the ceiling height is less than six (6) feet. In a house-trailer furnished by a person other than the occupants there shall be a minimum of twenty (20) square feet of clear floor area for each person sleeping therein.

(4) All shelters hereafter constructed or remodeled for family living quarters shall contain a minimum of seventy (70) square feet of floor space

for the first occupant and fifty (50) square feet of floor space for each additional occupant. Sleeping rooms in such family quarters shall also meet air space requirements of this section.

(5) Separate sleeping quarters shall be provided for each sex except in the housing of families.

(6) Each habitable room shall have at least one (1) window or skylight opening directly to the outside. The minimum total window area shall be ten (10) per cent of the floor area of each room. When the only window in a room is of the skylight type located in the roof of the building, the total window area shall be fifteen (15) per cent of the floor area of such room. At least one window or skylight shall be easily opened for ventilating the room. The total openable window area shall equal at least forty-five (45) per cent of the minimum window area required for a room except where board approved mechanical ventilation is provided. In computing total window area and openable window area, jalousie doors may be counted. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.09 Water Supply - (1) An adequate and convenient supply of water that conforms with the requirements of Chapter I of this code shall be available at all times in each camp for drinking, culinary, bathing and laundry purposes.

(2) The water supply shall provide at least thirty-five (35) gallons per person per day to the camp site.

(3) Adequate facilities for providing hot water for bathing and dishwashing purposes shall be available.

(4) In existing camps with water pressure systems, water outlets shall be located in such manner that no shelter or habitable area is more than one-hundred (100) feet distance from such an outlet. Drainage facilities shall be provided for the overflow or spillage from such outlets.

(5) In all camps hereafter constructed water under pressure shall be supplied to all buildings housing family living quarters and all other buildings in which cooking is permitted or which contain facilities for bathing, laundering or dishwashing.

(6) Where water is distributed under pressure a supply rate at least two and one half (2½) times the average hourly demand shall be possible and the distribution line shall be capable of supplying water at normal operating pressure to all fixtures.
(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.10 Garbage and refuse disposal - (1) All garbage, kitchen wastes and other refuse shall be deposited in metal cans with tight fitting metal coverings not to exceed twenty (20) gallons capacity. Such cans shall be conveniently located to all households throughout the camp area and shall be provided in sufficient number to handle all refuse from the camp.

(2) The contents of said cans shall be emptied and the cans cleaned as often as necessary to keep them and their surroundings in a sanitary condition.

(3) Provisions shall be made for disposing of the garbage, kitchen wastes and other refuse by incineration, grinding, burial or incorporation in a sanitary landfill.
(General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.11 Insect and rodent control - (1) Effective measures shall be taken to control rats, flies, mosquitoes and bed bugs and other insect vectors or parasites within the camp premises.

(2) No standing water shall be allowed to pool in the vicinity of the camp and the premises shall be kept clear of cans, rubbish and other articles that will hold water.

(3) No accumulation of materials shall be allowed that will breed flies.

(4) All windows, screens doors and outside openings in any camp shelter shall be protected with wire fly screening of not less than sixteen (16)-mesh. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.12 Heating - (1) When a camp is located in an area where prolonged temperatures below seventy degrees fahrenheit (70°F) are normally experienced during the period of camp occupancy, adequate heating equipment shall be installed in all living quarters.

(2) A stove or other source of heat shall be installed and vented in such a manner to avoid both a fire hazard and a dangerous concentration of fumes or gas. In rooms with wooden or combustible flooring, there shall be a concrete slab, metal sheet or other fire resistant material on the floor under every stove extending at least eighteen (18) inches beyond the perimeter of the base of the stove. Any wall or ceiling, not having a fire resistant surface within twenty-four (24) inches of a stove or stove pipe, shall be protected by a metal sheet or other fire resistant material. Heating appliances, other than electrical, shall be provided with a stove pipe or vent connected to the applicance and discharging to the outside air or chimney. Such chimney shall extend two (2) feet above the peak of the roof. A vented metal collar shall be installed around the stove pipe, vent or flue in a wall, ceiling, floor or roof through which the stove pipe, vent or flue passes.

(3) Automatically operated heat producing equipment shall be provided with controls to cut off the fuel supply upon the failure or interruption of flame or ignition or whenever a predetermined safe temperature or pressure is exceeded. All steam and hot water systems shall be provided with safety devices designed to prevent hazardous pressures and excessive temperatures. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.13 Lighting - Where electric service is available each habitable room in a camp shall be provided with at least one ceiling type light fixture and a separate double electric wall outlet. Other rooms in which people congregate, laundry rooms, shower rooms and toilet rooms shall be provided with a minimum of one ceiling or wall type fixture.. Electric wiring shall be installed in accordance with the provisions of local electrical ordinance or if no such ordinance exists, in accordance with the provisions of the National Electrical Code. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.14 Excreta and liquid waste disposal - (1) Facilities shall be provided and maintained in all camps for the satisfactory disposal or treatment and disposal of excreta and liquid waste.

(2) Such facilities shall be maintained in compliance with provisions of Chapter VI of the code. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.15 Plumbing - All plumbing shall be in compliance with provisions of Chapter VII of this code or local plumbing ordinances whichever establishes the higher standards. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.16 Toilets - (1) Approved toilet facilities adequate for the capacity of the camp shall be provided.

(2) Each toilet room shall be so located that no individual is required to pass through a sleeping area, other than his own, in order to use toilet facilities. Toilet rooms shall have a window area of not less than six (6) square feet opening directly to the outside. No flush toilet fixture or urinal shall be located in a sleeping room.

(3) A toilet facility shall be located within two-hundred (200) feet of the door of each sleeping room. No privies shall be closer than fifty (50) feet from any sleeping room, dining room, mess hall or kitchen. Privies shall comply with the requirements of Chapter IV of this code.

(4) Where the toilet facilities are shared such as in multi-family dwellings and in dormitory type facilities separate toilet rooms shall be provided for each sex. These rooms shall be distinctly marked "For Men" and "For Women" by signs printed in english and in the native language of the persons occupying the camp. If the facilities for each sex are in the same building they shall be separated by a solid wall or partition extending from the floor to the roof or ceiling.

(5) Where toilet facilities are shared the number of water closets or privies provided for each sex shall be based on the maximum number of persons of that sex which the camp is designed to house at any one time, in the ratio of one (1) such unit to each fifteen (15) women and one (1) such unit to each twenty (20) men within a minimum of two (2) units for any shared facility. Family living accommodations containing private toilet facilities shall not be considered when establishing this number of shared toilet facilities.

(6) Urinals shall be provided on the basis of one for each twenty-five (25) men. The wall and floor space to a point of one (1) foot in front of the urinal lip, four (4) feet above the urinal and one (1) foot to each side of the urinal shall be faced with a non-absorbent material.

(7) Every water closet or flush toilet hereafter installed shall be located in a toilet room and shall be properly connected to a satisfactory disposal system which complied with the requirements of Chapter VI of this code. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.17 Washrooms, bathrooms and laundry tubs - (1) Approved washing, bathing and laundry facilities adequate for the capacity of the camp shall be provided.

(2) Where they will be used by more than one (1) family or by non-family group, separate washrooms and bathrooms conveniently located shall be provided for each sex. Each separate facility shall be plainly designated "For Men" and "For Women". If the facilities for each sex are in the same building they shall be separated by solid walls or partitions extending from the floor to the roof or ceiling. Washrooms and bathrooms provided in family living accommodations shall be partitioned off from the rest of the room. Provisions shall be made for adequate dressing space adjacent to bathing facilities.

(3) Where wash-basins and shower baths are shared, wash-basins shall be provided in the ratio of one (1) for every twenty (20) persons and shower baths shall be provided with one (1) shower head for every twenty (20) persons or fraction thereof. All shower and wash fixtures shall be

provided with both hot and cold water under pressure.

(4) A two (2) - compartment stationary laundry tub or tray or other laundry facility for every twenty-five (25) families or fraction thereof shall be provided for laundry purposes and shall be convenient to all living quarters. Water under pressure shall be provided at each laundry tub or tray. Laundry facilities shall not be used for kitchen waste disposal. Laundry waste shall be disposed of in accordance with the requirements of Chapter VI of this code or in some other sanitary manner approved by the board.

(5) Family living accommodations containing private washrooms, bathrooms and laundry tubs shall not be considered when establishing the required number of shared facilities.

(6) The floors of toilet facilities shall be of smooth but non-skid finish and impervious to moisture and sloped to drain. Floor drains properly trapped shall be provided in all shower baths and shower rooms to remove waste water and facilitate cleaning. The walls and partitions of shower rooms shall be smooth and impervious to moisture. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.18 Food service facilities - (1) In camps where individuals or families are permitted or required to cook within their living quarters, stoves shall be installed in accordance with provisions of sub-section 170C-32.12(2) of this chapter. Conveniently located facilities, consisting of sinks supplied with hot and cold water under pressure in a ratio of one (1) to ten (10) persons or one (1) to two (2) families shall be provided. Provision shall be made for safe storage and refrigeration of food.

(2) In camps where cooking facilities are used in common, the kitchen shall be screened with wire fly screening of not less than sixteen (16)-mesh. Stoves, installed in accordance with provisions of sub-section 170C-32.12 (2) of this chapter, and sinks, supplies with hot and cold water under pressure, shall be provided in a ratio of one (1) to ten (10) persons or one (1) to two (2) families. Provision shall be made for safe storage and refrigeration of food.

(3) All shelters hereafter constructed or remodeled for family living quarters shall provide a stove installed in accordance with provisions of sub-section 170C-32.12(2) of this chapter, a sink supplied with hot and cold water under pressure and a refrigerator capable of maintaining temperatures below fifty degrees fahrenheit (50°F); provided, that this sub-section shall not apply in camps which limit all food preparation and service to central mess or multi-family feeding operations conducted in accordance with provisions of sub-section (4) below.

(4) In camps where there is a central mess or multi-family feeding facility such as a dining room or mess hall, it shall be operated in compliance with Chapter XVI of this code except where the type of service is limited as so described in sub-section (5) below.

(5) Camps operating field kitchens shall be inspected and approved by the board and shall comply with the following minimum requirements:

(a) Food preparation equipment, eating utensils and service facilities shall be so made or constructed as to be easily cleaned and shall be maintained in a safe and sanitary condition at all times.

(b) Cleaning and bactericidal treatment of utensils and equipment shall be performed in accordance with the provisions of Chapter XVI of this code.

(c) Field kitchens, dining rooms, mess halls and other areas where food is prepared or served shall be screened with wire screening of not less than sixteen (16)-mesh. All screen doors shall be self closing and open outward.

(d) Adequate provision shall be made for the sanitary storage and protection of food supplies and adequate refrigeration and equipment, capable of maintaining temperatures below fifty degrees fahrenheit (50°F) shall be provided for the storage of meat, milk and other perishable foods. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.19 Beds and bedding - (1) Sleeping facilities shall be provided for each camp occupant. Such facility shall consist of beds, cots or bunks complete with springs and shall include clean mattresses and mattress covers or mattress ticks filled with clean straw or other suitable material free from dust or burlap. Mattresses, mattress ticks, blankets and other bed coverings provided by the camp operator shall be laundered or otherwise sanitized between assignment to different camp occupants.

(2) All sheets, pillowcases, blankets or other bed coverings provided by the camp operator shall be kept and maintained in a sanitary condition by camp occupants.

(3) Regular inspection of beds and bedding shall be made to insure freedom from vermin. Bedding shall be treated with an insecticide as necessary to prevent vermin infestation. When vermin are found or reported, effective extermination measures shall be undertaken immediately.

(4) Every bed, cot or bunk shall have a clear space of at least twelve (12) inches from the floor. There shall be a clear ceiling height of not less than thirty-six (36) inches above any mattress and there shall be a clear space of not less than twenty-seven (27) inches between the top of the lower mattress and the bottom of the upper bunk of a double deck facility. Triple deck facilities shall be prohibited and in sleeping rooms provided for other than family groups, double beds shall be prohibited.

(5) Single beds, cots or bunks shall be spaced not less than thirty (30) inches laterally or end to end and double deck facilities shall be spaced not less than thirty-six (36) inches laterally or end to end. A minimum of four (4) feet of clear aisle space shall be provided in all barracks and dormitories. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.20 Fire protection - All buildings in which people sleep or eat shall conform to the requirements established by the laws of this state and regulations or standards issued by the state fire marshall. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.21 Sanitary maintenance of premises - All tents, buildings, shelters or other structures and the entire premises of the camp shall be maintained in a clean, safe and sanitary condition, free from rubbish, waste paper, garbage and other refuse. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.22 Responsibility of camp operator (1) The camp operator shall be responsible for complying with all statutory requirements and regulations issued thereunder relating to camps and with all conditions stated in the permit issued to him under these regulations.

(2) The permit required under these regulations shall be posted and kept in a conspicuous place in the camp by the camp operator.

(3) The camp operator himself shall inspect daily or provide a competent individual to inspect daily the grounds and common-use spaces of buildings, structures or tents including toilets, showers, laundries, mess halls, dormitories, kitchens or any facilities relating to the operation of the camp and see that each is maintained in a clean and orderly condition and that the buildings are kept in good repair.

(4) The camp operator shall inform himself of the rules and regulations relative to the reporting and control of communicable diseases adopted by the board and shall comply with the pertinent requirements thereof.

(5) It shall be the duty of the camp operator, where no physician is in attendance at the camp, to report immediately to the local health department in the county where the camp is located any person in the camp affected with any disease designated as reportable in the rules and regulations of the control of communicable diseases adopted by the board and to insure the complete isolation of such person.

(6) There shall be adequate medical and nursing care at or available to all camps.

(7) No person known to be infected with any disease in a communicable form or to be a carrier of such disease shall be employed in the operation of maintenance of a camp. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 FS)

170C-32.23 Camp supervision - All camps housing fifty (50) or more persons shall be supervised by a qualified resident supervisor who may be the camp operator or the camp operator's agent or employee. All camps housing less than fifty (50) persons shall be supervised and regularly inspected by the camp operator or his designated agent or employee. All persons designated as camp supervisors shall be jointly responsible with the camp operator for the sanitary condition of the camp. The name(s), telephone number, address or instructions how to locate the camp operator and supervisor shall be kept posted in a prominent location in the camp at all times. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 (FS)

170C-32.24 Responsibility of occupants - Every occupant of the camp shall use the sanitary and other facilities furnished for his convenience and shall comply with all applicable camp regulations which may concern or affect his conduct. (General Authority 381.031 (1) (g) 3 FS Law Implemented 381.031 (1) (g) 3 FS 381.472 ES)

CHAPTER 59-476

HOUSE BILL NO. 269

AN ACT relating to the State Board of Health; defining migrant labor camps; requiring that such camps be licensed; providing for the application, issuance and revocation of license; authorizing the board to issue regulations; providing for right of entry; and setting an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF FLORIDA:

Section 1. Definitions. - The following words and phrases shall mean:

(1) Migrant labor camp. One (1) or more buildings or structures, tents, trailers, or vehicles, together with the land appertaining thereto, established, operated or used as living quarters for fifteen (15) or more seasonal, temporary or migrant workers whether or not rent is paid or reserved in connection with the use or occupancy of such premises, provided however, this definition shall not apply to forestry or tobacco farm operation.

(2) Board: The State Board of Health.

Section 2. License required for establishment, maintenance or operation of migrant labor camp. - No person shall establish, maintain or operate any migrant labor camp in this state without first obtaining a license therefor from the board and unless such license is posted and kept posted in the camp to which it applies at all times during maintenance or operation of the camp.

Section 3. Application for license. - Application for a license to establish, operate or maintain a migrant labor camp shall be made to the board in writing and on a form and under regulations prescribed by the board. The application shall state the location of the existing or proposed migrant labor camp, the approximate number of persons to be accommodated, the probable duration of use and any other information the board may require.

Section 4. Issuance of license. - If the State Health Officer is satisfied, after causing an inspection to be made, that the camp meets the minimum standards of construction, sanitation, equipment and operation required by regulations issued under Section 6 of this act, he shall issue in the name of the board the necessary license in writing on a form to be prescribed by the board. The license, unless sooner revoked, shall expire on June 30 next after the date of issuance unless renewed, and it shall not be transferrable. All applications for renewal shall be filed with the State Health Officer thirty (30) days prior to its expiration on form blanks furnished by the board.

Section 5. Revocation of license. - The State Health Officer may revoke a license authorizing the operation of a migrant labor camp if he finds the holder has failed to comply with any provision of this act or of any regulation or order issued hereunder.

Section 6. Authority to issue regulations. - The board shall make, promulgate and repeal such rules and regulations as it may determine to be necessary to protect the health and safety of persons living in migrant labor camps, prescribing standards for living quarters at such camps, including provisions relating to construction of camps, sanitary conditions, light, air, safety, protection from fire hazards, equipment, maintenance and operation of the camp and such other matters as it may determine to be appropriate or necessary for the protection of the life and health of occupants. Regulations adopted hereunder shall be a part of the Sanitary Code of Florida created by 381.031 (1) (g) 12. and may be enforced in the manner provided in 381.031 (4), and violations thereof shall be subject to the penalties provided in 381.411.

Section 7. Right of entry. - The board and/or its inspectors may enter and inspect migrant labor camps at reasonable hours and investigate such facts, conditions, and practices or matters, as may be necessary or appropriate to determine whether any person has violated any provisions of this chapter or rules and regulations of the board pertaining hereto are being violated. The board may from time to time at its discretion publish the reports of such inspections in its monthly bulletin.

Section 8. Effective date. - This act shall take effect immediately upon its becoming law.

Approved by the Governor June 19, 1959.

Filed in Office Secretary of State June 20, 1959.

INSPECTION FORM - CAMPS

(AUTHORITY: Chapter 381, Section 381.422 - 381.482 Florida Statutes and Chapter 170C-32, Florida State Sanitary Code)

Date ______________________
Permit No. ______________________

Number of Occupants ______________
Name ______________________
Owner ______________________
Address ______________________

Location ______________________
Person in charge ______________
Address ______________________

1. CAMP SITE

Adequate drainage ______________
adequate size ______________
approved location ______________
____

2. SHELTER

Structurally sound ______________
All openings properly screened ______
Approved floor elevation & construction
____
Floor space adequate ______________
Approved ceiling height ______________
Adequate ventilation ______________
Window area adequate ______________
Air volume in sleeping quarters adequate ______________
Adequate beds provided ______________
Beds of proper design and adequately spaced ______________
Beds and bedding properly maintained & vermin free ______________
____

3. HEATING AND LIGHTING

Heating adequate, if needed ______
Heating facilities properly installed ___
____
Approved wiring ______________
Adequate illumination ______________
____

4. FIRE PROTECTION

Adequate fire control measures ______
____

5. FOOD SERVICE

Central mess and/or field kitchen facility ______________
Attach separate inspection report - per Chapter 170C-16. When provided common kitchen facilities properly screened ___
______________________;
Stoves and sinks adequate __________;
Adequate supply of hot and cold water under pressure ______________;
Provision for safe food storate and refrigeration ______________;
Properly maintained ______________
Where provided, individual or family kitchen facilities adequate ______
____

6. WATER SUPPLY

Adequate and approved supply and distribution ______________
Adequate hot water for bathing and dish washing ______________

7. SANITARY FACILITIES

Properly located ______________
Adequate Toilets ______________
Adequate Urinals ______________
Adequate Lavatories ______________
Adequate Showers ______________
Separate facilities provided for each sex in central units ______________
Properly identified ______________
Adequate window area ______________
Area and fixtures clean and properly maintained ______________
Privies comply with Chapter 170C-4 ____
____
Satisfactory laundry facilities ______
____

8. PLUMBING

Comply with Chapter 170C-7 or local Code ______________
Properly operating and maintained ____
____

9. SEWAGE DISPOSAL

Approved design & capacity __________
Satisfactory operation ______________
____

INSPECTION FORM - CAMPS
(Continued)

10. GARBAGE AND TRASH DISPOSAL

Adequate number of approved cans______

____

Collection and disposal satisfactory__

____

11. PEST CONTROL

Satisfactory rodent and insect control

____

____

12. GENERAL

Premises properly maintained__________

Daily Inspection provided______________

Resident camp supervisor provided______

Adequate medical and nursing care available______________________________

Adequate communicable disease control

and knowledge_________________________

and measures__________________________

____

An inspection of this camp has been made this date. Your attention is called to those items not in compliance with provisions of Chapter 170C-32, Florida State Sanitary Code. Satisfactory compliance must be made within ______ days or your permit will be subject to revocation.

Copy of Inspection report received______________________________
(Owner, Manager, Person In Charge)

Sanitarian____________________________ ____________________County Health Dept.

FLORIDA STATE BOARD OF HEALTH SAN 435 (Rev. 5/62)

ALACHUA COUNTY HEALTH DEPARTMENT

Edward G. Byrne, M. D., Director

Area of County: 892 square miles

Resident Population: 86,500

Number of Migrants: 1,500

Migrant Project Staff: 1 Public Health Nurse
1 Senior Sanitarian

ALACHUA COUNTY

DOMESTIC AGRICULTURAL MIGRANT

SITUATION IN PROJECT AREA

The migrant population usually reaches its peak in Alachua County between April and mid June. Apparently the drought and other adverse conditions in south Florida caused them to leave that area and arrive here much earlier (January). It should be noted that there was very little work for them at that time.

There were around fifteen-hundred (1500) migrants, this figure includes dependents, here during the peak spring crop harvest. The peak working migrant population was 800 - 1,000 this year. Half the number of the spring population can be expected for the fall harvest peak.

The ethnic makeup this year had not changed. It is as follows: Negroes 75%, Texas Mexicans 20%, and Caucasians 5%. This percentage background will remain true until about June 20 when most of the Mexican and Caucasians have gone, leaving an increase in the Negro percentage. See attachment - Exhibit A.

Major localities from which migrants come are Broward, Dade, Palm Beach, St. Lucie, and Sarasota counties. Most of them will go to Delaware, Maryland, New York, North Carolina, South Carolina, and Virginia when they leave here.

Local area farm workers who migrate are still very insignificant in number. People leaving the stream to become residents are more than balancing residents joining the migrant population.

There was no major labor shortage this year, although minor shortages appeared in the celery fields. A late winter freeze, early spring drought, decrease in planted acreage and increase of mechanization kept labor numbers from being critical this year. Mechanization of crop harvesting, particularly beans, is expected to increase.

FAMILY HEALTH SERVICE CLINIC

During the past twelve months, two types of clinics have been held in Alachua, Nursing and Medical clinics. Alachua is the center of the migrant area. Nursing clinics are staffed by one staff nurse, one paid worker and one volunteer worker. This clinic is held every Thursday from 10:00 a.m. to 4:00 p.m. Medical clinics are twice a month and are staffed by two staff nurses, one physician, one mid-wife, and one paid worker. The clinic is open from 9:00 a.m. until noon.

During the year twenty-four (24) Medical clinics were held and had an attendance of six-hundred (600). Fifty (50) Nursing clinics were held with a total of twenty-eight hundred and ten (2,810). Five (5) spot clinics were held in the area of two migrant camps with approximately one-hundred (100) persons attending.

Services available and offered to migrants were mental health, nutritionist, sanitarian, druggist, vocational rehabilitation, educational (school), nursing, physician and dentist services. Also, arrangements have been made for migrants to receive treatment at local hospitals for emergency room services.

Approximately seventy-five per cent (75%) of the patients seen in clinics were in the adult group with the remainder being children.

Something new this year was the night clinic - twice a week from 7:00 p.m. to 9:00 p.m. in Alachua. It was staffed by a physician and a nurse. Flyers were placed in migrant camps and the post office and crew leaders and growers were informed of this service. Drug stores in Alachua and High Springs were asked to accept prescriptions stamped "Migrant" brought in by migrant workers. Two physician in High Springs and one in Alachua were interviewed and agreed to see the migrants at times when no night clinic was open. This night clinic was located in the health department clinic in Alachua.

A number of referrals were made to other agencies, such as the Tumor Clinic, T.B. Association, Medical Center, and Alachua General Hospital.

It was found that the individual migrant took very little responsibility for carrying out his referral. The crew leaders or farmer as a rule took the migrant to his or her appointment.

During the year educational efforts were expended thru meetings with growers, community leaders, personal contacts with crew leaders, and the individual migrant. Individual counseling was given to the migrants in the matters of venereal disease, maternity care, tuberculosis, nutrition, communicable disease, child spacing and immunization needs of both children and adults. Thru individual counseling an extra effort was made with each migrant to know and understand his health needs and the ways available to meet these needs.

Because of the locations of the migrant camps, it was found by both the nursing and the sanitation staffs that the best way to work with the migrant was thru personal contacts with migrants, farmer, and crew leaders.

During the season five migrants were found to have active TB and were hospitalized. One-hundred and fifty (150) x-rays of contacts were made. P.P.D. tests were also made. Two children screened had complete physicals and were placed on I.N.A.H. One other child and one adult were x-rayed and continued on I.N.A.H.

The service of our TB consultant and TB staff nurse were available for screening, consultation, and evaluation.

Referrals were made out for the two children (mother admitted to South West T. B. Hospital) to have periodic physicals and continue on I.N.A.H., also a four-months supply of I.N.A.H. was given to them. Vitamins and iron tonics were supplied for the children and a five-months supply of medication was given to the adult.

Several migrants were involved in accidents while in the county. They were all treated at the Alachua General Hospital emergency room.

A spot clinic was held in the LaCrosse area, centrally located to migrant camps, which made available such things as immunization, worm medication, child spacing services, nutrition, growth and development for children, and maternity services. The same services were also available every Thursday from 10:00 a.m. - 4:00 p.m. in the Alachua clinic and all migrant groups were invited to use them. If specific services were not available at this clinic, a referral was given so needs could be met.

The number of migrants in the area at the peak of the season was approximately 1,000.

NURSING SERVICES IN CAMPS OR OTHER PLACES WHERE MIGRANTS LIVE IN PROJECT AREAS

During the past year, there has been one full-time staff nurse working in the general migrant labor area, and two part-time nurses. There were three part-time, paid employees and three volunteer employees for the clinic operations. The project nurse estimates that there are eight to ten population concentrations that have received service.

Approximately 1,200 field visits were made in the project area during the past year. Twenty per cent of these visits were to migrant laborer families. Approximately 80% of the migrants visited were given some type of referral for additional services such as health department clinics, private M.D.'s, Pediatric Charity Clinic, and Welfare Department. Approximately one-half of those given referrals carried through and completed referrals. Lack of transportation, working hours and apathy are the main reasons for not completing referrals.

Major hindrances to proper health services seem to be due to lack of camp organization, centralized health facilities, and apathy on the part of individual migrants to assume responsibility for determining their own health needs and problems. The most effective approach to the migrant seems to be through personal contact, by nurse and sanitarian, with growers and crew leaders.

SANITATION SERVICES RELATED TO

MIGRANT HOUSING AND WORK LOCATIONS

Staff

Personnel list and percent of time spent on project work:

1	Health Officer	5%
1	Sanitation Director	5%
1	Sanitation Supervisor	5%
1	Senior Sanitarian	100%
6	Non-Project Sanitarians	5%
1	Sanitarian Aid	2%
1	Clerk-Typist	1%
1	Clerical Personnel	2%

The full-time senior sanitarian is the only individual of the above list being paid by the Migrant Health Project grant. All other personnel are part of the local contribution to the project.

Location of camps within the project area are found on the attached map Exhibit "B". The majority of the migrants do not live in these camps. Instead, they choose to live in rooms, homes, trailers, etc.

Provisions of the Florida State Sanitary Code provide laws, regulations, or other criteria for evaluation of camps.

MIGRANT LABOR CAMP LEGEND

(Camp Numbers Relate to Camp Locations on Exhibit "B")

CAMP NO.	MIGRANT LABOR CAMP NAME
1.	Island Grove Growers & Shippers
2.	Beverly Hills Plantation
3.	Wilburn Hague
4.	N. T. Thomas, Sr.
5.	Roy Cellon
6.	Worth Harris
7.	Mo-Bo Produce Company
8.	Mo-Bo Produce Company
9.	Lacy Dokes
10.	Mo-Bo Produce Company
11.	Joe Imler

One-hundred seventeen (117) camp visits have been made to the eleven (11) recognized camps. Three (3) of the eleven (11) camps have ceased to operate during the year, leaving a balance of eight (8) camps still operating. Minimum standards have been met in two (2) of the remaining eight (8) and are in the process of being permitted. The six (6) substandard camps have all made improvements.

The major methods used in obtaining correction of camp defects have been:

1. Conferences and discussions with the camp operators.
2. Health education to those living in and/or operating a camp.
3. Conferences and discussions with the camp owners.

4. Frequent and complete inspections of camps and their facilities.

5. Enforcement of standards.

Camps in the area are never filled to capacity due to the fact that other facilities seem to be available. They seem to prefer facilities other than camps.

The major location for migrant housing remains in the northwest and western areas of the county plus the low-income areas of cities and towns.

Nuisance control, water supply, garbage and rubbish disposal, sewage disposal, and food service are regulated by the Florida State Sanitary Code. Single and duplex family residences or rooming houses are not regulated by the Sanitary Code.

There have been two-hundred and thirty-four (234) visits made to one-hundred and seven (107) sites other than camps. Most of the thirty-two (32) housing units visited had garbage and rubbish disposal problems. Most of them have been corrected. Many of the defects found in the housing units were created by the lack of or misuse of facilities.

One-hundred and sixty-five (165) visits were made to the one-hundred and forty (140) fields that use migrants for approximately fifty per cent (50%) coverage.

Drinking water is furnished to all fields with portable water coolers. The ice used in the coolers is purchased from approved sources. Camp water supplies have had bacteriological tests. These supplies meet potable water standards. Hand washing facilities are still lacking.

Sanitary facilities in the fields last year consisted of one privy. Several farmers are now using approved chemical toilets. Instructions have been received to serve notice on all growers to provide toilets.

The Florida State Sanitary Code is used for evaluating field sanitation.

Personal contact and group meetings of growers, migrants, camp managers, group leaders, and others is a major means of education.

COUNSELING ON SPECIFIC PROBLEMS BY TYPE OF PROBLEM

Personal Hygiene	98
Water Supply	65
Sewage Disposal	121
Campsite	43
Plumbing	54
Sanitary Facilities	130
Insect & Rodent Control	81

Structure	136
Food Service	93
Garbage & Trash	219
Fire Protection	43
Construction	96
Heating & Electricity Use	73
General	351
TOTAL	1,603

Personal Hygiene - Cleanliness and maintenance of personal body

Example: A migrant is found to have body lice. He is instructed by the sanitarian on how and why he should rid his body of the lice.

Water Study - Requirements of the Sanitary Code regulate all water supplies.

Example: A water sample was taken from a camp well which does not pass minimum standards. The sanitarian instructed the owner how to chlorinate the well. This was done and the well cleared up and produced water meeting minimum standards.

Sewage Disposal - New sewage disposal systems need the approval of the Alachua County Health Department. All systems are inspected for compliance.

Example: A new septic tank is to be installed. Minimum size and installation requirements set forth by the Code are given to the owner. The system must be approved before it is put into use.

Campsite - Maintenance of the campsite is provided by the owner.

Example: A migrant is found to be collecting junk and storing it along-side the main camp building. The sanitarian explains why the material should not be kept there and selects a better storage area.

Plumbing - Must be in accordance with the Sanitary Code. Misuse, inadequate maintenance and lack of fixtures create a large number of problems.

Example: A camp group was found placing articles in the commodes which stopped them up. Group education by the sanitarian halted the misuse.

Sanitary Facilities - New labor camps and field sanitary facilities need approval prior to construction.

Example: A new labor camp is contemplated by a grower. Plans must conform to the Sanitary Code and be approved.

Insect & Rodent Control - There is usually a high concentration of insects and rodents due to location, personal habits, and very poor basic sanitation practices.

Example: Chemicals and insecticides are recommended by the sanitarian to a camp owner to rid the premises of vermin.

Structure - Importance of good maintenance is conveyed to growers, operators, crew leaders, and migrants.

Example: Reasons are given to a grower why he should regularly maintain his camp instead of waiting until the end of the season.

Food Service - This includes both public and private food service.

Example: The temperature of a refrigeration unit in a migrant restaurant does not meet standards. The owner is told what temperature is required and why. As a result the situation is corrected.

Garbage & Trash - Storage and disposal are a constant problem.

Example: A crew leader is dumping garbage and trash on private property. The dumping is stopped and the crew leader informed of the location of an approved dumping site.

Fire Protection - All camps receive fire protection from the Florida Forest Service or a volunteer fire department.

Example: A conference is held with a migrant family about the danger of building fires along-side of the camp structure.

Construction - New housing or remodeling of existing ones is needed.

Example: A grower is having trouble securing labor because of no housing facilities. The sanitarian proves to the grower that good housing would encourage migrants to work for him.

Heating & Electricity Use - Performance of heating units and electricity is the major criteria used to judge working order. Units must meet acceptable safety standards.

Example: The sanitarian found an electric heater with raw exposed wires being used by an individual. Information on the dangerous condition was given plus instructions on how to repair the unit.

General - Areas of counseling not previously mentioned.

Example #1: A migrant is found to be harboring a calf inside the camp building. The sanitarian discussed the situation with the migrant and points out a convenient location where he can keep the calf.

Example #2: A grower was found to be a tuberculosis contact of a migrant and he did not want to be x-rayed. He was informed by the sanitarian of the true facts pertaining to tuberculosis, what needed to be done, and why. This conference resulted in excellent cooperation from the grower.

TYPES OF INDIVIDUALS AND GROUPS WITH WHOM WORKING RELATIONSHIPS WERE ESTABLISHED AND PURPOSES OF RELATIONSHIP

Alachua County Building & Zoning Department

Cooperation, coordination, and development of programs dealing with zoning, sewage, structural standards, etc.

Alachua County Vegetable Growers Association

Development of housing and sanitation programs for growers and migrants.

Florida Employment Agency

Improvement and coordination of a cooperative program.

Alachua County Agricultural Agent

Improvement and cooperation of housing and sanitation programs.

Alachua County TB Association

Cooperation in facilitating the hospitalization of migrant patients.

PROVISIONS MADE FOR ORIENTATION AND IN-SERVICE TRAINING OF STAFF

Staff members are sent to state-wide and sectional organization conferences where they are kept abreast on national, state, and local levels of thinking.

The General Staff Meeting, held once a week, irons out general problems and coordinates activities.

University of Florida and health department libraries are open to the staff who are encouraged to use the available resources.

PROBLEMS WHICH PREVENT OR HINDER GROWERS IN MAKING IMPROVEMENTS AND MAINTAINING THEM

The major problem the grower faces in this area is economics. This problem is magnified by the fact that the mores and folkways of this group are not conducive to the acceptance of socialized programs.

This area seems to be in a poor location for raising truck crops as they usually start harvesting while south Florida is still active or when more northern areas open up. These conditions cause poor prices for the local products.

Three camps have closed this year with the possibility that only one of these three will ever open up again. The total acreage has continued to decrease and will more than likely do the same next year. The late cold and dry spring has not encouraged expansion of acreage.

The project staff is continuing to use an educational approach for the obtainance of compliance with requirements and standards.

PROBLEMS PREVENTING OR HINDERING THE PROPER USE AND MAINTENANCE OF HOUSING AND FACILITIES BY MIGRANTS

Major problems are still the psychological, social, economic, and educational levels of the people involved. These problems cannot be completely corrected by the passage and enforcement of laws. Changes must come from within the people themselves.

The lack of housing and facilities which meet standards is still a grave problem.

GENERAL APPRAISAL OF RESULTS OF SANITATION SERVICE

Most migrants, except for crew leaders and field walkers, do not accept any more responsibility than they absolutely have to. Many of the crew leaders and field walkers are also hesitant in the acceptance of responsibility and this fact has been demonstrated many times.

Field facilities have been increased this year, but still many migrants make use of the woods. Visual observation and conferences with migrants have brought out this fact.

The provision and maintenance of facilities by camp and other owners is accepted by them as a responsibility up to a point. The new wage and hour laws have contributed nothing toward creating awareness of their responsibilities.

The people of the community have a reasonable understanding of the migrant situation, but their relationship continued to be one of nonassociation. Migrants do not belong to the local group, but are needed to gather the crops and this is the community attitude. Migrant individuals who settle in the area are accepted for what they make of themselves.

The grower-migrant relationship is good and this is demonstrated by the fact that many of the migrants return to the same grower year after year.

It is not possible to report diseases stemming from poor housing and sanitation in a statistical manner at this time because so many diseases are untreated, unreported, or hidden.

GENERAL APPRAISAL OF ADEQUACY OF SERVICES

The migrant project has had greater success in all fields of endeavor than it did last year. This success has required a much greater effort from the staff than in the past and it will, more than likely, necessitate even greater effort in the future.

SPECIFIC INFORMATION AND SUGGESTIONS BASED ON THIS SEASONS' EXPERIENCE

Meetings and conferences with associations, growers, crews and individuals have still proven to be the most effective means of coordinating, planning and facilitating grower and migrant programs.

The recording system of functions performed still needs to be revamped. A new, more effective system has been presented by the state committee, but has not yet been implemented.

HEALTH EDUCATION SERVICES

No funds have been made available for the hiring of a full-time or part-time health educator this season. The sanitarian has performed the majority of the health education services in this area and has done an excellent job with the time available.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

Many migrants have training, experience and skills acquired from past employment, unions, armed services, etc. which they are not using at this time. It is believed, at present, that the unwillingness of the migrant to accept responsibility and the fact that he likes being in the stream are the main reasons for his present employment.

The staff, particularly the sanitarian, discovered the potentials among migrants by observation of work performance and the development of close personal working relationships with them. Migrants were counseled and guided by the sanitarian, trying to help them better themselves, but to little avail.

Those who were more willing to accept responsibility were the most cooperative with the staff. This group is made up of crew leaders, field walkers and the elderly.

The sanitarian developed a good working relationship with the migrant groups which resulted in their involvement with the project. Foregoing sections of this report tell the methods used to produce the more effective efforts and achievements.

There have been several groups and individuals especially cooperative with project efforts. The groups have been listed prior to this and the individuals are too numerous to list.

The problem of particular individuals or groups especially obstructive to the project has been nonexistent. The section on sanitation services related to migrant housing and work localities points out some of the difficulties encountered.

The greatest hindrance the project has encountered is the apathy of the migrant. This apathy will require time and work to change - if it can be changed.

Travel time required from the health department office to migrant camps and field locations is an obstacle which at present cannot be overcome. The improvement in records and record keeping methods needs immediate attention so that quicker decisions can be made.

SOURCES OF SUPPORT OTHER THAN THE FEDERAL MIGRANT HEALTH GRANT THIS YEAR (1966-67)

The project obtained financial support (estimated) from the following contributors:

Welfare Department (Burials)	$ 250.00
Dentists (Unpaid bills and donated)	$ 2,000.00
Health Department personnel (Time and travel)	$ 6,000.00
Health Department (Supplies, Migrant Transportation, etc.)	$ 650.00

Other sources of non-direct financial support are:

Alachua County Building and Zoning Department

Florida Employment Agency

Alachua County Agricultural Agent

Alachua County TB Association

Migrant Health Representative (United States Public Health Service out of the Atlanta office)

State Migrant Health Coordinator (Out of the Jacksonville office)

Support from these and new sources will continue to expand as they have done this year.

As stated before, improvement of data collection and reporting needs attention. This office agrees with the recommendations of the Migrant Labor Records Committee.

MIGRANT PROJECT OBJECTIVES

-1968-

(1) To improve environmental health factors having an influence over the migrants and their families.

(2) To develop a better record keeping system.

(3) To provide medical services for migrants and their families.

(4) To provide dental services for migrants and their families.

(5) To motivate the migrant to improve his own environment and health.

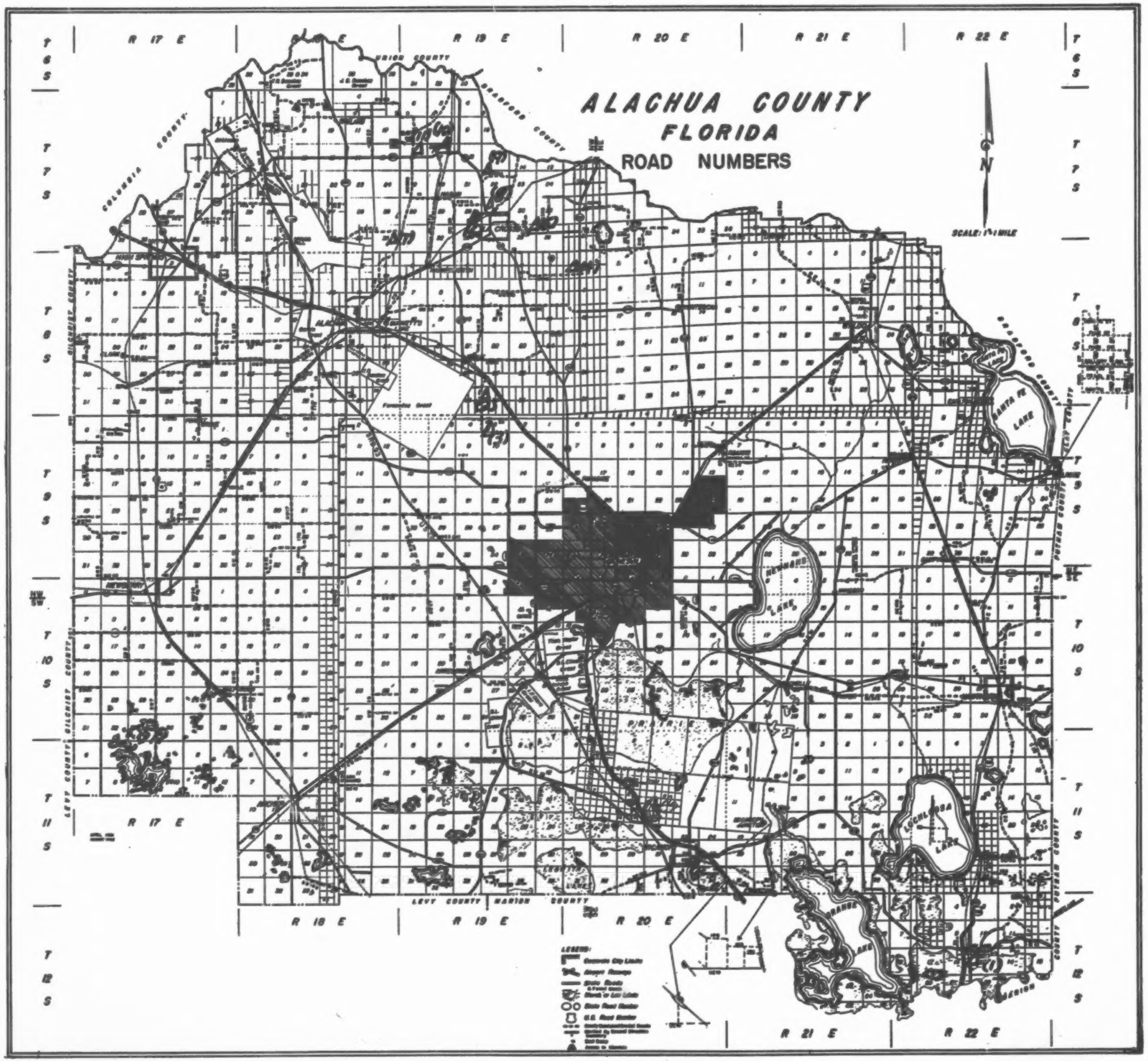
(6) To provide clinics in areas of migrant population.

EXHIBIT "A"

ETHNIC BACKGROUND

	Per Cent 1966 - 1967	Percentage Change Since 1965 - 1966	Percentage Change Since 1964 - 1965
Negro	75	Constant	-28
Texas Mexican	20	Constant	100
Caucasians	5	Constant	Constant

(EXHIBIT B)


ALACHUA COUNTY
FLORIDA
ROAD NUMBERS
SCALE: 1"=1 MILE
R 17 E
R 18 E
R 19 E
R 20 E
R 21 E
R 22 E
T 6 S
T 7 S
T 8 S
T 9 S
T 10 S
T 11 S
T 12 S
UNION COUNTY
BRADFORD COUNTY
COLUMBIA COUNTY
GILCHRIST COUNTY
LEVY COUNTY
MARION COUNTY
PUTNAM COUNTY
SANTA FE LAKE
NEWNANS LAKE
LOCHLOOSA LAKE
ORANGE LAKE
LEGEND:
Corporate City Limits
Airport Runways
State Road Number
U.S. Road Number

BROWARD COUNTY HEALTH DEPARTMENT

Paul W. Hughes, M. D., Director

Area of County:	1,218 square miles
Resident Population:	400,000
Number of Migrants:	14,000
Migrant Project Staff:	1 Public Health Nurse Supervisor 2 Public Health Nurses 1 Sanitarian 1 Clerk-Typist

BROWARD COUNTY MIGRANT HEALTH PROJECT

ANNUAL PROGRESS REPORT

April 30, 1966 - April 30, 1967

INTRODUCTION:

Our progress in the field of migrant health has been evidenced in part by the fact that the agricultural workers is more aware of the existance of the medical and dental facilities available to him in this area.

More and more frequently referrals for follow-up care have been received from various states utilizing migrant workers. This not only enables the nurse in the field to contact the patients, but in a large part, the patients have taken the initiative to seek out the migrant health centers.

During this report year it is estimated that there were approximately 12,000 to 14,000 migrants (including dependents) in the area during the peak of the season, which occurs in December, January, February, and March. Although there was a definite increase in the number of migrants coming into the area during the season, there was a decrease in the number of camps due to the various problems encountered by the individual camps in meeting adequate health standards.

Nature was good to the farmers in the area this year. Torrential rains cost only minor crop damages at the beginning of the growing season. Several of the farmers had not planted their crops when the rain came, and even those who had, were able to recoup their losses.

Picking machines are being used in greater numbers than ever. Next year, one farmer will be going totally into bean machines. In tomatoes, the moving of operations to Mexico is becoming more of a factor. This change may affect the total number of migrants needed for menial tasks, but in the long run, might increase the need for workers, specifically in machine operations and packing houses. This in itself is helping to meet the objective of raising the level of the migrant task from menial to semi-skilled, therefore, causing an awareness in the migrant for self improvement.

The number of know Texas-Mexicans decreased this year throughout the county to approximately seven per cent. Three per cent were Caucasians. The Negro population increased to fifty per cent, while Puerto Ricans remained forty per cent. The majority of the Negroes migrate to North Carolina, Virginia, and New Jersey, while the Puerto Ricans work mainly in New York, Michigan, South Carolina, and New Jersey. There are still many Puerto Ricans who return home to Puerto Rico at the end of the season. Although the working season ends around the first of April (due to the freeze in central and northern Florida this year) as well as cold weather farther up the stream, the migrants remained in this area well into the month of May.

FAMILY HEALTH SERVICE CLINICS:

The Migrant Project has provided medical clinic services since its beginning in 1964. These clinics continue to provide one of the most important services to the migrant and his family. The medical clinic schedule includes one afternoon and three night clinics per week, which is an increase of one clinic per week as compared with the same period last year (1966). This year we were very fortunate in obtaining the services of a general practitioner of Spanish origin. The Puerto Rican families soon became aware of this physician and thus the clinic facilities were used more by the Spanish-speaking populace than before.

MIGRANT CLINIC HOURS AND SESSIONS

CLINICS - May - October, 1966

Monday: 6:00 - 9:00 p.m. Medical

2 Nurses
1 Doctor
1 Clerk - Medical and Dental

6:00 - 9:00 p.m. Dental

1 Dentist
1 Nurse
2 Volunteers

Wednesday: 2:00 - 4:00 p.m. Medical Only

2 Nurses
1 Doctor
1 Clerk

CLINICS - November, 1966 - April, 1967

Monday: 6:00 - 9:00 p.m. Medical

2 Nurses
1 Doctor
1 Clerk - Medical and Dental

6:00 - 9:00 p.m. Dental

1 Dentist
2 Volunteers

Tuesday: 2:00 - 4:00 p.m. Medical Only

1 Doctor
2 Nurses
1 Clerk

Wednesday: 6:00 - 9:00 p.m. Medical and Dental

Medical

1 Doctor
2 Nurses
1 Clerk - Medical and Dental

Dental

1 Dentist
1 Nurse

Thursday: 6:00 - 9:00 p.m. Medical Only

1 Doctor
2 Nurses
1 Clerk

First and third Thursday of each month - Mobile Health Unit - Labor Camp
Second Thursday - Mobile Health Unit - Butler Camp - Deerfield
Fourth Thursday - Mobile Health Unit - Cheshire Camp

CLERICAL:

In August of 1966 the clerical position was filled. This relieved the nurses of some time consuming tasks. Due to a familiarity with the migrant way of life, the clerks rapport with the patients was invaluable.

The mobile health unit was initiated primarily to introduce medical services to the migrants in the outlying camps. During the last season the unit was taken on a bi-monthly basis to two of the largest camps. A noteworthy point was that patients seen on the unit one night would return to the stationary project clinic for further visits. The migrants were made more aware of our total facilities and lack of transportation was not really the problem.

The clinic sessions continue to operate on a "semi-emergency" basis, thereby making it impossible to anticipate either the number or the type of service to be rendered. For example, last July a newborn infant, placenta intact, weighing 2 pounds, 11 ounces, was brought to the clinic door. The family was new in the area and did not know the location of the hospitals, but they did know the location of the Migrant Health Center. The clinician tied the cord, emergency measures were carried out and the baby and mother were quickly transported by ambulance to the hospital. This baby girl now weighs 12 pounds, 10 ounces, and the mother takes her out in the fields daily while she works.

In last year's annual report, we discussed a patient who came into the clinic for the removal of a bullet imbedded in his thigh. The accident had occurred two days prior to clinic, therefore, the doctor felt the area was so traumatized that it was inadvisable to remove it at that time. To continue our story, two months ago the patient came back to the clinic. The bullet had worked its way to the surface, and this year it was removed.

Another interesting case was that of a patient who came to the clinic with a second degree burn covering the entire top of his left foot. He stated that he was drunk and had fallen asleep in front of his home. Two young girls poured cigarette lighter fluid over his foot and set fire to it. The clinician debrided the area and the patient returned daily for dressing changes for two weeks. Today the wound is completely healed, and the man is able to resume work.

Table 1 shows the clinic sessions, hours, and visits.

TABLE 1. - Migrant Health Clinic, Pompano Beach, Florida
April 30, 1966 through April 30, 1967

TABLE 1. (Continued)

Clinic Sessions	164
Clinic Hours	471
Patient Visits	3874

There were 164 clinic sessions totaling 471 hours and 3,874 patient visits made during this reporting period.

Table 2 indicates by whom the patients were seen.

TABLE 2. - Type of Patient-Visits to Migrant Health Clinic,
Pompano Beach, Florida
April 30, 1966 through April 30, 1967

Nursing	657
Nurse and Doctor	3217

Three-thousand, eight-hundred and seventy-four patient-visits were made to the clinic, of these visits 657 were seen by the public health nurse and 3,217 were seen by the public health nurse and physician.

Table 3 shows the distribution of the patient-visits by condition or disease.

TABLE 3. - Distribution of Patient-Visits to Migrant Health Clinic,
Pompano Beach, Florida
April 30, 1966 through April 30, 1967 (by Condition or Disease)

CONDITION OR DISEASE	VISITS
Immunizations, without Disease	655
U.R.I.	607
Dental	511
Skin	446
C.V.D.	357
G.I.	216
Eyes, Ears, Nose and Throat	184
Trauma	176
Gyn.	131
Neuro.	123
Intestinal Parasites	99
Venereal Disease	63
Allergy	50
Ortho.	36
G.U.	35
Tuberculosis	23
Maternity	18
Tumor	12
Arthritis	16
Communicable Disease	8
Eye Screening	8
Anemia	4
Asthma	4

TABLE 3. (Continued)

Child Spacing	4
No Disease	3
Blood Dyscrasia	1
Poison	1
Diabetic	82
TOTAL	3,874

Upper respiratory, immunizations without disease, and skin disease or conditions accounted for 44% of the patient visits to the clinic. Gastrointestinal, E.E.N.T., traumatic, neurologic, and gynological conditions or diseases accounted for 24%. Allergy, V.D., Orthopedic, Gastro-urinary, T.B., Obstetrics, Tumor, Arthritis, Communicable Disease, Eye-screening, and all other conditions accounted for the remaining 32%. All dental patients are cleared by the physician before their initial dental visit. There was also a 33% increase over last year's cardio-vascular patients. We are now carrying 16 diabetic patients on a regular basis. Some of these were diagnosed through the clinic, but the majority were known diabetics who sought out our service. Twenty-two (22) Cervical Cytology smears were taken, 119 tuberculin tests were read, and 120 blood sugar analyses (Destrostix) were done.

Drugs continued to play an integral part of our medical service. The clinics experience now includes examination by the physician, evaluation, and follow-up with medication, making it a total service rendered. This year, 2,092 prescriptions were filled and 1,353 samples were given.

Table 4 illustrates the patient-visits by age and sex.

TABLE 4. - Patient-Visits to Migrant Health Clinic,
Pompano Beach, Florida
April 30, 1966 through April 30, 1967
(by Age and Sex)

AGE	MALE	FEMALE	TOTALS
Under 15	932	919	1,851
15 - 44	495	763	1,258
45 and over	418	347	765
TOTALS	1,845	2,029	3,874

Female patients accounted for over half of the visits with 2,029 as opposed to 1,845 males. The 15-year and under group comprised 47% of the total visits made, while the 15 to 45 year age group constituted 33%. Those over 45 years totaled 20%. The large number of visits by the under 15 year group is in part due to the number of immunizations given in the clinics.

Approximately one-third of all referrals made were to the County Health Department for maternity, x-ray, and venereal disease services. One-fifth of the patients were referred to the hospital for services we were unable to render. Patients who were eligible for County Welfare services were referred there for follow-up.

Table 5 shows the distribution of patients referred for further services to other sources from Migrant Health Clinic, April 30, 1966, through April 30, 1967.

TABLE 5. -

OTHER SOURCE	REFERRED
Health Department	49
Welfare Department	52
Hospital	31
Specialist	11
Cardiac	1
Lion's Club	1
Police	1
Migrant Mission	1
Social Security	1
TOTAL	148

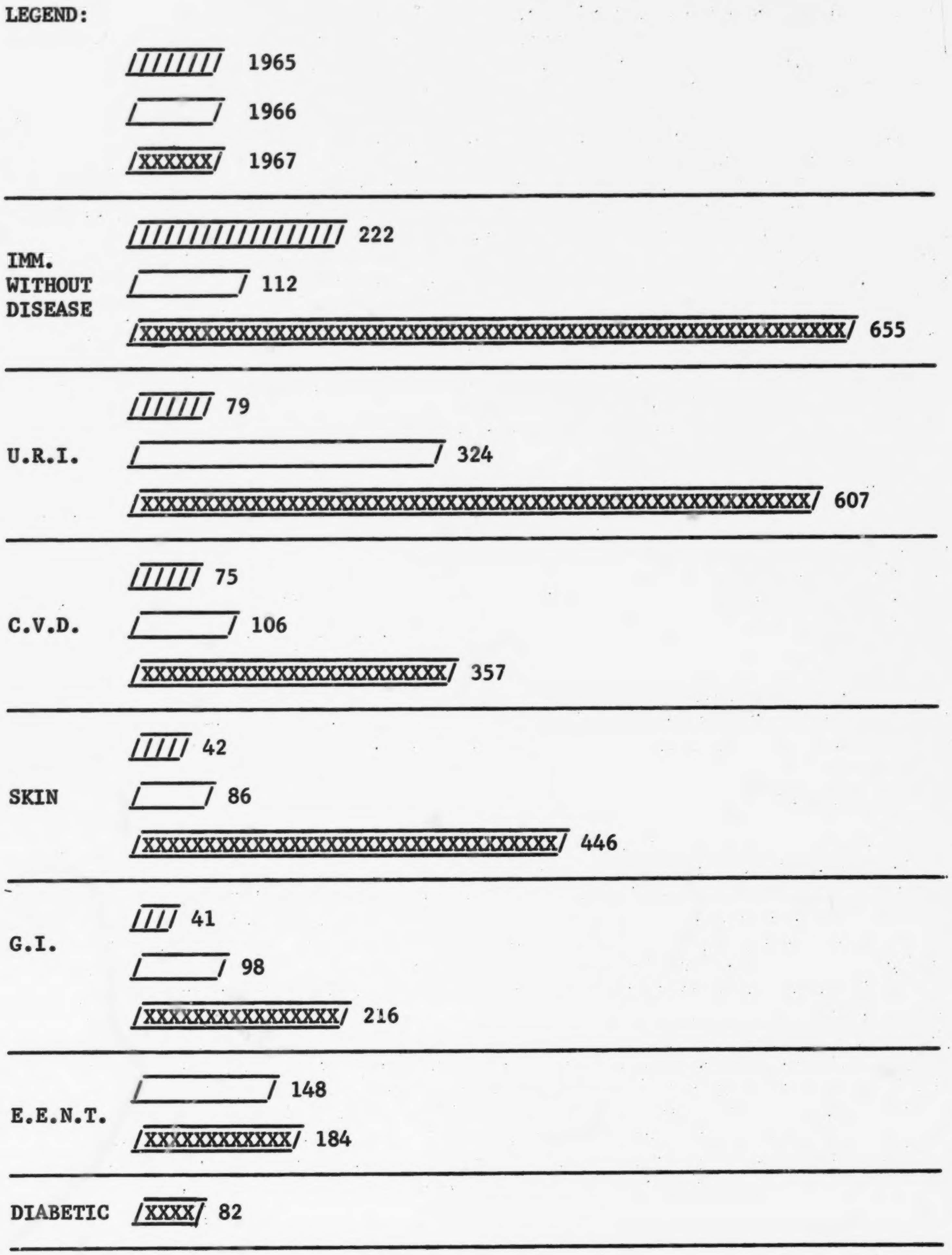
Though payment for emergency room care to local hospitals is now possible for verified migrants, this funding was not available during the working season. Referring patients for either emergency or inpatient care continued to present a problem. Due to lack of money, the migrant was not able to obtain the services needed.

Interest in migrant affairs is ever increasing in the community. This is evidenced by a recent visit of two students from Florida Atlantic University working toward their Masters and Doctorate degrees. They felt that a day in the field with the public health nurse gave them a better understanding of the migrants. They had little concept of what was being done for the migrants through the health programs, as well as little knowledge of their living facilities and way of life.

Because of interest shown by the patients, posters were added to the already available literature. These were soon followed by films, appropriate to the migrant's needs, at each night clinic. These films and posters varied in content from hygiene, communicable diseases and nutrition to dental care, among other subjects.

Health teaching and counseling is carried on for a large part in the home rather than during the clinic sessions due to the type of services rendered. In the clinic each patient is seen by the physician; however, who discusses his condition with him while the nurse reinforces the use of the medication, as well as any follow-up care needed.

As shown in previous tables, clinic visits have increased by over thirty-five per cent. The graph (next page) compares five of the leading conditions or diseases treated for the two and one-half years the project has been in existance.


LEGEND:
1965
1966
1967
IMM. WITHOUT DISEASE
222
112
655
U.R.I.
79
324
607
C.V.D.
75
106
357
SKIN
42
86
446
G.I.
41
98
216
E.E.N.T.
148
184
DIABETIC
82

C

DENTAL CLINIC:

As there are no other dental clinics available to adults in this county, the project desperately needed a second dental clinic. We were able to fulfill this need when a second dental clinician joined our staff. At present, the dental clinics are held in conjunction with the night medical clinics two nights each week. The clinics are equipped only for extractions; however, it is hoped that in the future these facilities can be extended.

In midsummer of 1966, a local couple became aware of our need for volunteer workers in the dental clinic. They worked in various capacities wherever needed. Their aid and cooperation made it possible for the nursing staff to devote more time to the needs of the medical clinic. The second dental clinic was still limited in that the couple was only able to be at the clinic one night a week. However, with the implementation of the project budget in March, 1967, a dental assistant was hired.

Table 6 indicates patient-visits to Migrant Dental Clinic by Age and Sex.

Table 6. - Patient-visits to Dental Clinic, Migrant Health Clinic,
Pompano Beach, Florida
April 30, 1966 through April 30, 1967

AGE	MALE	FEMALE	TOTAL
Under 15 years	148	181	329
15 - 44 years	219	299	518
45 years and over	124	88	212
TOTAL	491	568	1,059

Total Number of Clinic Sessions	64
Total Number of Patients Seen	1,059
Total Number of Extractions	1,857

NURSING SERVICES:

Public health nursing service was provided to the migrant and his family by three public health nurses who devote 100% of their time to Migrant Project activities. The workload during the "season" is extremely heavy for all Migrant Project personnel. One public health nursing position had been vacant (due to nursing shortages) and this made it necessary for the two remaining nurses to work 12 hours on three days each week. Toward the end of the season, everyone on the project was exhausted. (The third nursing position was filled in May.)

Field visits by the public health nurses are directed toward teaching the migrant personal hygiene, self-improvement, home improvement, as well as the medical treatment needed. Specifically speaking, these services include health teaching and demonstrations in the areas of maternal and child health, family planning, school health, communicable disease control (including tuberculosis and venereal disease), mental health, and chronic diseases.

During the clinic sessions, the nurse assists the doctor, screens the patients, obtains pertinent information, does dextrostix testing for diabetes, urinalysis, gives immunizations, and discusses follow-up care with the patient. This year she also assisted the dentist for the majority of the season.

Since the public health nurse also functions as the school nurse, she was able to carry out several special projects throughout the year. With the assistance of the State Board of Health, a dental survey was carried out at the Pompano Project Elementary, a migrant school. This survey included examination of each child by the State Board of Health dental hygienist. The Broward County staff dentists and the dental hygienist cleaned the teeth of all students and applied fluoride treatment. Follow-up was then done by the public health nurse to insure that dental treatment was given where needed, either for fillings or extractions.

An Immunization Program was also carried out in the school. Each student was given the complete series of immunizations; including oral polio, smallpox and diphtheria, whooping cough, and tetanus inoculations. Within the first two months of school, each child's vision was tested and referred to physicians - when found necessary.

The two public health nurses made 818 field visits during the reporting period. The following shows a "breakdown" of these field visits:

SERVICE	VISITS
Child Health Service under:	
1 year	146
1 - 4 years	47
5 years and over	47
Tuberculosis	97
Maternity	251
Chronic Disease	82
Miscellaneous	148

Two active cases of tuberculosis were discovered through voluntary x-rays taken by the State unit in December, 1966. As a result, the public health nurses of the Migrant Project made a house-to-house canvas of the 320 homes in the Pompano Labor Camp, requesting each member of the family over 18 years to obtain a chest x-ray. The County unit was then taken to the outlying farms and 11 additional cases of active tuberculosis were found. Six of the thirteen required immediate hospitalization and the remainder were placed on prophylactic medication.

Attending one of our clinics was a Puerto Rican mother and her children. She requested medical care for one of the children who was suffering from an "ear ache." Upon further questioning, it was discovered that she had taken three of her seven children out of a Tuberculosis Sanitarium in Puerto Rico just prior to her arrival in this country. Skin testing with PPD of the entire family was done immediately, with readings of 24 to 40 mm on five members of the household. Routine follow-up was carried out.

FUTURE PROJECT DEVELOPMENT:

General Objectives:

(1) To improve the general health status of the migrant and his family.

(2) To motivate the migrant to improve his health and health conditions.

To help accomplish the above, we propose to:

(1) Enlarge clinic operations (increase the number of night clinics and services), thus enabling us to serve more patients.

(2) Increase the number of field visits by the public health nurse to familiarize the new migrants in the area with our services. More intensive teaching in the field of nutrition, particularly:

  (a) Diabetes

  (b) Cardiovascular Diseases

(3) Maintain records of program activities and accomplishments that will reveal such items and services that should be expanded.

(4) Increase the number of migrant health service referrals made and the number of personal health records given.

(5) Increase the amount of information relating to the Migrant Project disseminated to the public.

The project objectives continue to be met with the addition of one extra night clinic, bringing the total to three. This is an important factor, as the migrant works all day and is unable to attend afternoon sessions.

Though emergency room funds were not available during the season, and inservice funds have not been allocated to date, we are hoping both will solve many problems.

Community involvement by the migrant is becoming more and more evident. Last summer several mothers attended a program sponsored by Marymount College learning home economics as well as fundamentals of science and English. Another mother has returned to school through the Aid to Dependent Children funding of State Welfare. This summer plans are in the making for the head of the migrant household, male or female, to attend classes in learning a technical skill. The Migrant Neighborhood Youth Corps is also sponsoring a compensatory education and work experience program for migrants 15 years and up who are still in school.

The Migrant Program is firmly established in the community and is being used to a large extent by those in need of its services. The contribution of the program to the overall improvement of the health status of the migrant would seem to be immeasurable.

This portion of the report was prepared by: Migrant Project Staff
Elsie Sweitzer, Super. Nurse
Sally Titus, Staff Nurse
Margie Lewis, Clerk
Barbara Driscoll, Staff Nurse

SANITATION SECTION:

Staff	Effort
1 Sanitarian	100%
1 Sanitarian Supervisor I	25%
1 Sanitation Director II	5%
1 Sanitary Engineer	Consultant

During the past year, child care centers were taken over by a specialist.

The sanitarian in charge of nursing homes and mobile units was consulted on appropriate problems.

Laws, Regulations, or Criteria for Evaluating Camps:

In the evaluation of camps, authority was used under House Bill 269, Chapter 59-476, and inspections followed. The Sanitary Code, Chapter 170C-32 was also used as a basis for camp inspections and evaluations.

The following is a list of the Migrant Labor Camps in Broward County, Florida:

(1) Davie Caretakers
(2) Butler's Farm Labor Camp
(3) Hinson Brothers Quarters
(4) S & M Farms
(5) Whitworth Brothers
(6) Pompano Beach Farm Labor Camp
(7) Hinson and Spears
(8) Thomas Whitworth (Lyons Boulevard)
(9) John Whitworth (Lyons Boulevard)
(10) W. W. Cheshire (Sample Road)
(11) John Whitworth (Wiles Road)
(12) W. B. Brown
(13) M. McJunkins
(14) R. Cheshire
(15) Hinson
(16) Hinson (2nd St. & 2nd. Ave.)
(17) B. T. Lewis
(18) Amergo Bruschi
(19) Parker
(20) Fifth Street Camp

NOTE: The above named camps and camp numbers relate to the information contained on the following page.

Number of Camps in Area by Size and Type of Occupancy:

1966-1967 SEASON ESTIMATED MIGRANT POPULATION OF BROWARD COUNTY CAMPS

	AGE Under 15	SEX		AGE 15-44	SEX		AGE 45-64	SEX		AGE 65+	SEX	
		M	F		M	F		M	F		M	F
1.	0	0	0	32	32	0	0	0	0	0	0	0
2.	60	28	32	120	55	65	20	5	15	6	4	2
3.	5	2	3	50	40	10	0	0	0	0	0	0
4.	0	0	0	140	138	2	20	20	0	0	0	0
5.	15	7	8	16	8	8	2	1	1	0	0	0
6.	900	400	500	450	175	275	140	62	78	10	7	3
7.	10	6	4	6	3	3	0	0	0	0	0	0
8.	7	3	4	18	8	10	4	2	2	0	0	0
9.	7	4	3	19	16	3	0	0	0	0	0	0
10.	20	12	8	6	3	3	0	0	0	0	0	0
11.	35	20	15	50	20	30	10	4	6	0	0	0
12.	10	6	4	5	2	3	1	0	1	0	0	0
13.	25	14	11	30	20	10	0	0	0	0	0	0
14.	60	32	28	30	10	20	10	5	5	0	0	0
15.	4	2	2	12	6	6	0	0	0	0	0	0
16.	20	12	8	12	6	6	0	0	0	0	0	0
17.	0	0	0	15	10	5	10	5	5	0	0	0
18.	0	0	0	40	20	20	0	0	0	0	0	0
19.	12	7	5	6	3	3	0	0	0	0	0	0
20.	7	4	3	42	37	5	0	0	0	0	0	0
Total	1197	559	638	1099	612	487	217	104	113	16	11	5

NOTE: Camp names relate to the corresponding numbers on the preceding page.

SANITATION SERVICES RELATED TO CAMPS

Purpose of Visit	Nov. '65-Apr. '66	May '66-Apr. '67
Complete Inspections	20	50
Follow-up Inspections	39	87
Conferences:		
Operator	43	75
Resident Manager, etc.	21	49
Occupant	0	30
Contractor	4	6
Health Department Staff	13	51
Owner or Agent	3	25
Water Samples	30	45
Complaints	19	29
Dog Bites	2	3
Other:		
Sewage Disposal	14	30
Kitchen Inspections	6	14
Information	89	68
TOTAL Visits	304	562

Number of Camps which Met Existing Standards at Beginning of Season:

Most of the camps in Broward County are open from fall to spring, and then the occupants move out. Three of our permitted camps operate to some degree year around. The fourth closes completely. This fourth camp is an all male Puerto Rican camp and is developing a reputation for its seasonal deterioration. Efforts to get supervisors and occupants to assume responsibility have been futile.

Number of Camps Brought Up to Standard During Project Period:

Three of our formerly permitted camps are on notice to upgrade or replace facilities. One has done so and is in the process of being repermitted. Another, our largest camp, the Pompano Labor Camp, operated by the Housing Authority of the City of Pompano, was not issued a permit and is currently on notice for operating without a permit. The third made minor repairs but did not complete the upgrading needed. (These people had a fire prior to the season which necessitated the purchase of new machinery. Thus, due to a high capital outlay, major repairs were eliminated. One camp not permitted the previous year was issued a permit. Twelve camps have instituted some form of progress that is aimed at meeting existing standards. Six camps ceased operation this year.

Number of Defects Found by Type:

To list the specific number of defects would be irrelevant. With the closing of some camps and the tearing down of others, this statistic may be closer to reality.

Number of Defects Corrected by Type:

Here again, a number is not available. Main efforts were aimed at getting basics of:

(1) A structure that is sound, keeps out rain, wind and bugs;

(2) A place to go to the toilet;

(3) A facility for washing bodies;

(4) A facility for washing dishes.

Progress is this area is slow due to the money it takes to put in facilities. Also, many people who are required to spend money feel it is a waste, due to the abuse these facilities often get. A major effort is made to have major improvements be on a logically sound basis, not just a conformation to the code, but a necessary facility for anyone to live a decent life. Portable toilets are suggested in any instance where community facilities are used. This eliminates malfunctioning toilets and gets the feces out of the wash room.

Comparative Data Available from Previous Years:

The six camps that closed this year will join a file of over twenty camps previously eliminated.

Other Types of Housing Used by Migrants:

Broward County is considered the home base for many migrants. They often live in apartments and rooming houses in the following areas:

1966-1967 Season Estimated Migrant Population of Broward County Communities

	AGE -15	SEX		AGE 15-44	SEX		AGE 45-64	SEX	
		M	F		M	F		M	F
Deerfield	500	250	250	150	50	100	50	15	35
Pompano Beach	1000	500	500	300	100	200	0	0	0
Carver Homes	150	75	75	60	15	45	0	0	0
Collier City	200	100	100	100	40	60	0	0	0
Other Areas	6500	3250	3250	2250	850	1400	750	300	450
Totals:	8350	4175	4175	2860	1055	1805	800	315	485

NOTE: Camp populations previously listed are not included in the above figures.

What has, and is, happening is that as camps are closed, shacks torn down, and pay increased, the migrant element is moving into rental units. Although this often results in apartments that are quite messy, it has taken these people from shacks and now they have basic shelter, water, toilets, etc.

Laws, Regulations, or Other Criteria for Evaluating Housing Outside of Camp:

Migrants seem to seek out the more dilapidated, unorganized area to live in due to their unstable wage, etc.

City building departments carry out extensive condemnation programs to eliminate undesirable structures and/or those lacking in facilities.

The county building department has condemnation powers but as yet has not used them.

Much of the sanitarian's efforts are aimed at garbage control, using a sanitary nuisance notice developed for this purpose. An effort is being made to hold the occupant responsible for the garbage and mess rather than the owner. The problem is created by the tenant; and in the case of improper handling of his own garbage, he should be held responsible.

Garbage in migrant-infiltrated areas is a major problem for many reasons, some of which are:

(1) Migrants often come from areas of poor garbage control and expect it as the way of life.

(2) Due to the large families and unstable financial position, garbage quantity depends on finances. Little garbage when times are hard; (drop service, handle themselves). Much garbage when times are good; (too much to handle themselves but do not reinstitute pickup service).

(3) Migrants will try to use any type of container to save buying one. (Owner wants migrant to buy because he will take it when he leaves.)

(4) Trash removal in the county is also on an individual basis; and due to the expense involved in individual removal, it is often non-existent.

It is felt that lack of effective garbage control is the major contribution to slum-type conditions. If you control the garbage, the slum atmosphere lessens.

The total migrant population is not permanently definable due to Florida and Broward County being the home base for so many migrants. When work is available, the wives, older daughters, older sons, and non-working husbands work the fields. Crew leaders will pull through a community with their busses and pick up workers here and there. Some areas are not too bad; some are pitiful. An attempt is made to work on the most pitiful due to the fact that the manpower is not available to handle it totally.

Total Number of Visits Made to Other than Camp Locations by Purpose of Visit

	Nov. 65 Apr. 66	May 66 Apr. 67	Nov. 65 Apr. 66	May 66 Apr. 67
	NUMBER		TOTAL VISITS	
Water Samples	8	5	10	6
New Septic Tanks Installed	15	15	16	25
Schools	--	7	--	18
Child Care Centers	1	4	2	17
Complaints Investigated	27	87	94	229
Nuisance Corrected	--	--	22	78
Rabies (Animal Bites)	11	32	31	64
Eating and Drinking Establishments	7	26	12	52
Grocery and Meat Markets	9	20	11	26
Private Premise	26	6	39	21
Public Premise	9	16	13	52
TOTALS:	114	218	251	588

Field Sanitation:

Efforts in this area again were minimal.

Most field drinking water is either drawn from camp taps or community supplies. Camp supplies were checked regularly by the project sanitarian and community supplies are constantly checked by operators.

Some camps have portable toilets which serve a dual purpose when field workers are close enough. An economically feasible field toilet to our knowledge has not yet been developed. Until such is done, this area will leave much to be desired. Broward County does not allow the construction of field privies.

There have been some improvements in field eating units but most of these leave much to be desired.

Educational Effort with Migrant:

Films (Housefly and Insects, Carriers of Diseases) were shown to some community groups in an effort to improve garbage and trash control.

Films were shown at maternity clinics to improve the migrants' knowledge as regards health education.

Camp personnel were talked to about different aspects of health:

(1) How the fly transmits disease - garbage control.
(2) Birth control measures.
(3) Water contamination problems.
(4) General housekeeping for health (hang clothes, throw things out).
(5) Importance of personal cleanliness.

With Farmer:

(1) Stress the need for a basic shelter, toilet, body washing facility, and dishwashing facility.

(2) Run the camp rather than let it run itself; this way some problems are avoided.

(3) Make demands on workers in terms of keeping their camp home clean.

Other Groups:

(1) Showing the film "The Season People" to those not familiar with the migrant to give them some background as to the magnitude of the problem and what is being attempted.

Working relationships were established with the following agencies:

Florida Hotel and Restaurant Commission: A dual agency attack on garbage, trash and building conditions in licensed areas. Two agencies are more effective in problem areas.

Housing Authority of the City of Pompano Beach: Dual frustration over the failure to secure the release of funds ($2,000,000) for rebuilding. This county could use help from any agency that could furnish the money to rebuild the largest camp in the county. The buildings and related facilities are a prime example of a facility impeding the progress of its people. Someone somewhere should get the ball rolling to rebuild these originally federally financed camps. They were - when built - a distinct advancement. Today they are outdated and a handicap to the people living in them.

The Housing Authority is currently on notice of operating without a permit. The next step is condemnation and closing. Total rebuilding is needed even though it won't eliminate many problems.

Building departments of Deerfield Beach, Pompano Beach, and Broward County: Cooperate effort to remove shack-type living and prevent the creating of more problems.

County Solicitors: Legal action to gain compliance with House Bill 269, and Chapter 170C-32 of the Florida State Board of Health Sanitary Code relating to camps; legal action relating to sanitary nuisances, Chapter 386.041, Florida Statutes.

Portable Toilet Operators: Futile attempt to find or develop an economically sound field toilet.

Community Action Fund - Community Action Program: Attempt to coordinate efforts.

Broward County Migrant Council: Attempt to steer efforts in the right direction.

Church Groups: Attempt to familiarize these groups with the magnitude and inter-relationship of problems so that "do good" efforts actually achieve their goal.

Provisions made for Orientation, In-Service Training, or Other Indoctrination:

The sanitarian attended the following:

The Florida Industrial Commission meeting in July. The information covered was enlightening in terms of what was being attempted and hoped for by another agency.

Food Handlers Course sponsored by the Broward County Health Department in October. Proper food handling habits.

The Anti-Poverty and Epidemiology sessions of the Florida Public Health Convention.

Quarterly meetings of the Florida Association of Sanitarians.

The Florida Migrant Health Conference in December. An excellent inter-organization information and idea exchanging meeting.

Florida Citizens Committee on Agriculture Labor meeting in March. Question the validity of the purpose, aims, and structure of this group. Good to know about, but not to be involved in.

Camp at Avon Park for Broward County Migrant Children. A positive activity of a "do good" group.

Problems in Project Operation:

The largest problem facing the migrant population in Broward County is the Pompano Labor Camp's failure to get funds for rebuilding. An outright grant of $2,000,000 would be well spent here.

Much of the problem is the migrant himself:

Due to the type of work and usually accepted environment, a particular caliber of person is attracted.

Some of the common problems he has are:

Uneducated - very little schooling.
Alcoholic - drink anything; wine, canned heat, beer, etc.
Lazy or lack of incentive - enough money for today.
Irresponsible - little concern for even himself.
Many children and often not married.
Unclean - his home, his body, his clothes.

Any one migrant may have one or all of the aforementioned problems, plus some not mentioned, and to correct the situation that is present means eliminating the problems. Much must be done to stimulate the migrant to help himself.

Suggestions:

Stronger teeth are needed in the sanitary nuisance notices. The migrants themselves should be charged and fined if necessary here. The sooner this is done the less time and effort it will take to get proper garbage control which not only affects the migrant, but the whole community.

A change in permit expiration date from June to September. Florida farming is done in the winter and camp work in the summer and fall. It is not logical for farmers to do major repairing prior to June.

Some kind of official criteria for allowing extra-legal camps that are improving to continue operation is needed. The present procedure is to verbally allow operation where good faith is shown. Verbal allowance of camps to operate leaves the health department wide open for harmful criticism.

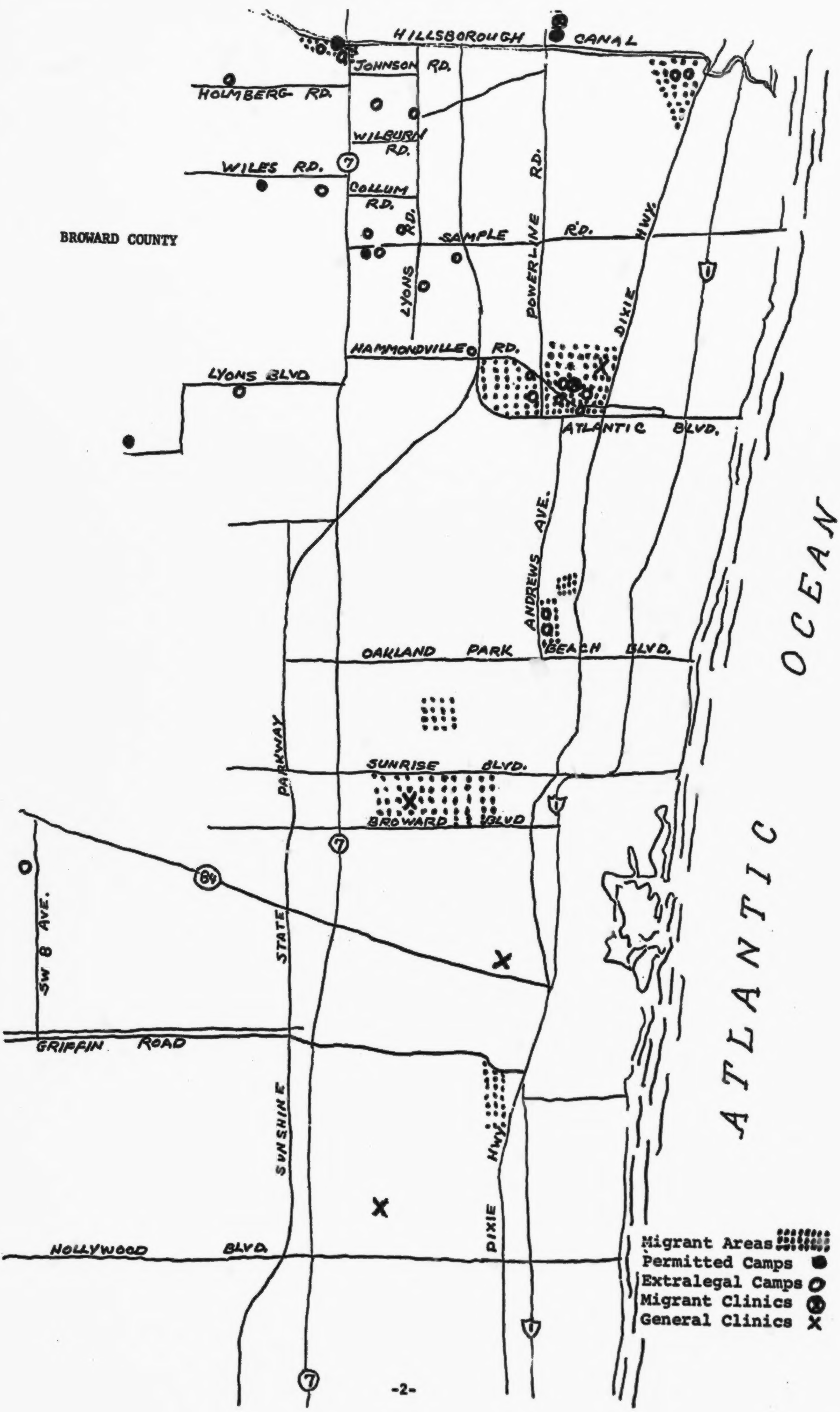
Continued emphasis should be placed on the control of the size of families. Approved housing for large families is not available due to economics. Migrants, therefore, squeeze into whatever they can get. Fifteen people living in a two-bedroom house is a problem in itself.

Due to the multitude of problems associated with supervising migrants, the number per camp should be kept as low as possible. Under 25 is ideal; 25 to 50 questionable; over 50 you have a major headache.

Revisions are needed in the inspection form. The present form is not basic enough. Possibly a form for separate areas such as Structure - Toilets, Sewage, and Water Supply - Sanitation and Garbage. The present form squeezes too much on one sheet and is often not effective.

The Revised Report Kit suggested at last year's Migrant Conference would be an improvement over the present kit.

BROWARD COUNTY


HILLSBOROUGH CANAL
JOHNSON RD.
HOLMBERG RD.
WILBURN RD.
WILES RD.
7
COLLUM RD.
LYONS RD.
SAMPLE RD.
POWERLINE RD.
DIXIE HWY.
1
HAMMONDVILLE RD.
LYONS BLVD.
ATLANTIC BLVD.
ANDREWS AVE.
OAKLAND PARK BEACH BLVD.
SUNRISE BLVD.
BROWARD BLVD
1
7
84
SW 8 AVE.
STATE PARKWAY
SUNSHINE
GRIFFIN ROAD
PIXIE HWY.
HOLLYWOOD BLVD.
1
7
ATLANTIC OCEAN

Migrant Areas ⁙
Permitted Camps ●
Extralegal Camps ○
Migrant Clinics ⊗
General Clinics X

COLLIER COUNTY HEALTH DEPARTMENT

Clyde L. Brothers, M. D., Director

Area of County: 2,032 square miles

Resident Population: 22,000

Number of Migrants: 19,000

Migrant Project Staff:
- 3 Public Health Nurses
- 1 Senior Sanitarian
- 1 Sanitarian
- 1 Equipment Operator
- 1 Dental Assistant
- 1 Clinic Aide
- 1 Clerk-Typist

MIGRANT SITUATION

COLLIER COUNTY

The 1966-67 migrant season was relatively uneventful. There were no deep freezes, and crops were harvested on schedule. At the peak of the season there were approximately 7,000 field workers, accompanied by an estimated 12,000 dependents. Acreage under cultivation totaled 25,000.

Ethnic backgrounds:	
30%	Texas-Mexican
25%	Caucasian
25%	Negro
20%	Puerto Rican

Arrivals started around October 1, 1966, and most departures had occurred by May 31, 1967.

Lines of travel were roughly the same as in prior years: A majority follow the Atlantic states, but many go to and from Colorado, Texas, Ohio, Michigan and Wisconsin. Late spring freezes in northern states which destroyed the fruit crops may result in alteration of the pattern of travel in 1967.

Approximately 50% of the migrants consider Collier County their home area, but their mode of living precludes establishment of local and state residency requirements. They are, therefore, excluded from any county or state welfare benefits.

Labor camps in operation totaled 120 and varied in capacity from 15 to 250. (See Sanitation Services and map of Collier County.)

FAMILY HEALTH SERVICE CLINICS

In the Immokalee Clinic, which serves about 96% of the migrants in the county, the clinic schedule is as follows:

Clinic Schedule

MONDAY:	
MCH Registered Nurse Conference, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 1:30 P.M.
Project "M" Registered Nurse Conference, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 4:00 P.M.
TUESDAY:	
Family Planning, 1 Nurse - Second Nurse	Only when necessary
Project "M" Registered Nurse Conference	
WEDNESDAY:	
MCH & Medical Clinic, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 3:00 P.M.

WEDNESDAY (Continued):

Project "M" Registered Nurse Conference, 1 Nurse — 9:00 A.M. to 12:00 Noon
1:00 P.M. to 4:00 P.M.

THURSDAY:

Immunizations — 9:00 A.M. to 12:00 Noon
1:00 P.M. to 4:00 P.M.

Family Planning & Project "M" Registered Nurse Conference
(1 Nurse in A.M. - 2 Nurses in P.M.)

FRIDAY:

Project "M" Registered Nurse Conference, 1 Nurse — 9:00 A.M. to 12:00 Noon
1:00 P.M. to 4:00 P.M.

Naples clinic day is Monday, but drop-ins are seen at any time during office hours. A majority of the migrants in the Naples area are seen in the emergency room of the Naples Community Hospital, which is staffed on a 24-hour basis seven (7) days a week.

The Everglades Clinic is operated on a full-time basis by a public health nurse. A physician holds medical clinic once a month. There are very few migrants in this area.

The Immokalee Clinic had two full-time public health nurses (one Project "M"); one part-time public health nurse; and two full-time clinic aides - interpreters. In April, 1966,a second project nurse was added to the staff.

Two full-time and two part-time nurses staff the Naples clinic.

All clinic sessions are conducted in Health Department buildings.

Ill or injured patients were given referrals to private physicians. Table I shows referrals by diagnosis, sex, age group, and ethnic group, but does not include revisits for the same illness or injury.

A total of 887 patients were treated in our clinics with drugs provided by State, County, drug manufacturers, and private physicians. (See Table II)

Table III shows patients referred to clinics outside the county, transported by our project bus and equipment operator.

Table IV lists dental services provided to under-privileged children.

Table V lists other services provided to migrants, and Table VI lists volunteer services by one physician and numerous other volunteers.

A part-time nutritionist was assigned, and was of great help to our MCH clinics.

We had planned to start evening clinics once a week when the second project nurse was employed, but the second nurse resigned because of ill health and the workload would have been too great for one nurse.

Family planning clinics continued at a high rate of activity, including pills and IUD's.

NURSING SERVICES

Project "M" Full-Time Registered Nurses	Two
Full-time non-project nurse	One
Half-time non-project nurse	One
Part-time (15%) non-project nurse	Three
Full-time clinic aide - interpreters	Two
Full-time social workers	Four (*)

(*) Paid for by School Board with Anti-Poverty funds. Worked closely with health department.

Again, home and camp visits by nurses were short of ideal due to the number of sick migrants reporting to clinics, but the situation showed improvement over prior years due to part-time availability of an additional Project nurse.

There are 120 migrant camps in the county, with 106 in the Immokalee area, and the others scattered throughout the county. (See section on Sanitation for more detailed information on camps.)

School health continued to receive high priority. Other nursing services are covered in the tables. Health education was the concern of all personnel. In addition, the Project nurse regularly conducted group instruction for MCH patients on diet, personal hygiene, care and feeding of infants, etc.

Tuberculosis screening continued to show results. During the calendar year 1966, a total of 22 active cases (a majority migrants) were admitted to state TB hospitals.

Immunization clinics continued to be well attended. Measles vaccine is now supplied by the State Board of Health.

Practicing physicians, hospitals, and clinics cooperated fully with the health department in providing health services to the migrants. As in the past, much of the service was donated.

Our original Project nurse was upgraded to a PHN III and was designated as Supervisor of Nurses in the Immokalee Clinic.

Many of the migrants are purchasing lots and buying trailers or building homes. Thus, a greater number remain in the area year round. In other cases, the adult males and the adolescent boys head north at the end of the season, leaving the mothers and other children in Collier County.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS:

(1) STAFF: The entire staff of Environmental Health worked on the project. They included: Sanitation Director I; Senior Sanitarian; Sanitarian; Sanitarian Trainee (2); and Clerk-Typist II. All workers are salaried.

TITLE	LENGTH OF TIME	DURATION	% OF TIME
Sanitation Director	Part-Time	All Year	19.5%
Senior Sanitarian	Part-Time	All Year	7.4%
Sanitarian	Full-Time	All Year	74.9%
Sanitarian Trainee	Full-Time	Employed 3/27/67	1.0%
Sanitarian Trainee	Part-Time	Employed 11/07/66	3.6%
Clerk-Typist II	Part-Time	All Year	20.0%
		TOTAL	125.4%

(2) Location of Camps on map accompanies this report.

(3) We use the Florida State Sanitary Code, Chapter 381 of the Florida Statutes, and the Collier County Building and Zoning Regulations. A Labor Camp is defined as living quarters for 15 or more persons.

(4) Capacity of Camps vary from 15 to 400 persons.

Number of Camps	Type	Number of Persons
27	Single Men	946
1	Single Women	40
92	Families	6,376 Adults
	(3 to a family)	9,564 Children
TOTAL 120		16,926

(5) The total number of camp visits was 1,808.
The total number of camps visited was 120.
The number of camps that met the standards at the beginning of the season was 52.
The number of camps that were brought up to standards during the season was 35.
The number of camps that met standards before they opened was 87.
The number of camps that met standards at the end of the season was 87.
Minor defects were found in 30 camps which were not permitted.
Five camps were closed during the season and four camps were not allowed to open. There are six camps with secondary sewage treatment provided. These six camps also have central water systems that meet the requirements of the Florida State Board of Health. The wells for the Immokalee Water System are drilled and construction of the system will be accomplished this year. This water system will supply at least one-half the Migrant population.

Our records do not reveal defects by type. We have records of the following inspections:

CODE	INSPECTION	NUMBER
P 16	Camp Inspection and Permits	352
P 19	Nuisance Complaints	231
P 20	Nuisance Corrected	176
X 12	Water Supplies Collected	188

(Continued)

CODE	INSPECTION	NUMBER
P 28	Other Food Establishments	450
P 6	Septic Tank Inspections	211
None	Miscellaneous	200
	TOTAL	1,808

Defects were corrected by direct personal contact in most cases. Florida State Board of Health Inspection Sheets were used to record the violations. Failure to obtain correction of defects is still due to lack of personnel. (Equivalent of one man, full-time, plus 20% Clerk's time.) There is a continued indifference on the part of many growers, farmers, operators, labor contractors and local officials.

COMPARATIVE DATA

CAMPS PERMITTED	TOTAL CAMPS	MIGRANTS	DEPENDENTS	TOTAL
1964 - 16	77			
1965 - 77	94	5,942		
1966 - 60	106	5,942	6,750	12,600
1967 - 87	120	7,362	9,564	16,926

YEAR	BEDS SHORT	BEDS ADDED	BEDS REMOVED	NET GAIN
1964	?	560	400	160
1965	2,000	650	400	250
1966	1,500	300	150	150
1967	2,000	730	220	510

(6) The remaining Naples Airport Housing was burned completely down and removed. At least 600 migrant families lived in single-family residences in Immokalee. There were 2,000 male workers living outside the county area.

(7) The Florida State Sanitary Code and the Collier County Building Code are used as a criteria for evaluating housing. Septic tank permits are required.

(8) Sanitation services to migrants outside of camps are not recorded separately and the figures are not available.

(9) Eleven-thousand acres of crops were visited - field sanitation. We have 30,000 acres plus under cultivation in Collier County.

(10) There are no field sources of water supply for drinking purposes known to the department. They probably wash their hands in a ditch as every field is surrounded by drainage ditches. Drinking water and soda pop are carried on the buses.

(11) Many field locations were visited in order to inspect privies and the common violation was open seats. The total number of violations would equal the number of privies - which is unknown. This defect was not corrected.

(12) The Florida State Sanitary Code is used for evaluation of field sanitation.

(13) Owners and management have been far more willing to cooperate than in previous years and individuals are making some progress.

(14) Owners and managers of all the camps were advised regarding the minimum requirements of the Code and maintenance.

(15) No persons were counselled on a group basis.

(16) Public health nurses, growers, crew leaders, and camp operators were used as contacts for information purposes, in cooperation with the State Employment Service and the U. S. Employment Service.

(17) During the Annual Teachers Project for academic credits, we stress the migrant situation. We also hold staff meetings of our personnel. We encourage our personnel to attend regional health group and Florida Public Health Association meetings. We participate in a variety of migrant seminars and courses. We have issued permits for construction of 14 homes under the Migrant Self-Help Project, with many more homes planned. The personnel of Vista have assisted us, to some extent, with the Migrant Project.

(18) Camps on short-term, leased land constitute the greatest problem in proper maintenance of general sanitation. On permanent camps, a more open-minded attitude by owners and managers was noted.

(19) Camps' and operators' acceptance of responsibility for sanitation has definitely improved, the the community understanding remains poor. Opinions are often published by people who have made no prior visits to these camps and therefore have no yardstick for appraising the true picture. The Grand Jury investigation and report resulted in some cooperation.

(20) Not all camps were served adequately and housing was not surveyed. Personnel shortage, insufficient transportation, and lack of cooperation made it necessary for the sanitarian to check and recheck even the smallest items. A full-time health educator is needed.

(21) The job classification of Migrant sanitarians should be upgraded. Incentive pay, cost of living bonus, and additional travel allowance would assist in recruitment of personnel. Legal assistance should be made available above the local level.

HEALTH EDUCATION SERVICES

No Health Educator was assigned to the project in Collier County. Efforts along these lines were made by all professional personnel, with some signs of progress.

Nutrition services were provided to migrants in Collier County from May 1 thru July 31, 1966 - and - from January 9 thru April 30, 1967.

As a part of these services diet counseling was provided to patients attending health department clinics. The type of diet instruction and number of patients counseled were as follows:

Type of Diet Instruction	Number Counseled
Maternity	110
Weight Reduction	15
Child Health	4
Diabetes, etc.	13

Group classes were conducted for maternity patients on various phases of nutrition. A series of evening meetings concerned with nutrition was offered to migrant parents of children in one of the day-care centers in Immokalee.

Nutrition and food budgeting was discussed with parents of children in the Headstart Program in both Immokalee and Naples. Normal nutrition was discussed with migrant teenagers participating in a Federal work-study program in Immokalee.

Shadowlawn Elementary School in Naples has a large number of migrant children in attendance. Six different class groups were taught about nutrition by the nutritionist.

Normal nutrition was discussed with adult migrant aides working in the schools at Highlands Elementary School and Bethune High School in Immokalee and at Carver Junior High School in Naples.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

Efforts continued to interest migrants in maintaining a healthful environment in camps. In instances where their camp owner appointed a camp manager, progress was significant. Efforts will be made in the future to encourage this practice.

As a result of a special meeting with the county agricultural agent as chairman, and involving the health department, county commissioners, county engineer, building and zoning department, and a good representation of growers, a better understanding was reached as to the mission and function of the health department in the supervision of labor camps. Standards were set and accepted regarding temporary labor camps on farms. Much of the land in cultivation in Collier County is leased on a year-to-year basis, and as a consequence the growers cannot afford permanent labor housing. Mobile units are constructed and moved to new locations as needed. Standards were set relative to spacing, ventilation, water, waste disposal, etc. By the end of the season all but one of the bootleg camps discovered last year were in compliance with the Code adopted at the meeting. We believe this meeting cleared the air of much misunderstanding and that we can expect better cooperation from the camp owners in the future.

All new permanent labor camps are required to have inside toilet facilities, showers, running water, cooking facilities and refrigeration.

Local physicians continued to support the project and many donated their professional services. Pharmacists continued to provide drugs at welfare rates.

The Naples Community Hospital admitted hundreds of patients for thousands of hospital days with no hope of compensation.

The addition to the Project staff of an additional nurse, sanitarian, and clerk should result in our being able to more adequately meet the growing demand for services.

TABLE I

PROJECT "M" - MEDICAL REFERRAL TO PRIVATE PHYSICIANS

		WHITE					MEXICAN				
DIAGNOSIS	SEX	0/1	1/5	5/15	15/45	45+	0/1	1/5	5/15	15/45	45+
ANXIETY	F				2					2	1
	M										
ARTHRITIS	F					1					1
	M									1	
CARDIO VASCULAR	F				2	1		1	1	2	
	M				2	2			1		1
COMM. DISEASES	F						1	1	2	1	
	M		5				4	8	1		
DENTAL	F			1							
	M										
DIABETES	F									1	1
	M				1					1	1
E.E.N.T.	F	1	2	1	5		2	9	6	3	
	M	3	4	3	4	5	2	13	10	2	
EPILEPSY	F				1	1				1	
	M					1			2		
G.I.	F	3	4	1	2	1	13	9	2	2	
	M	6	3	2	2	3	10	11	3	1	
G.U.	F			1	2			1		3	1
	M			1		2	1	2	1	2	
HERNIA	F										
	M	1			1				1		
MINOR & MAJOR INJURIES	F			3	5	1		5	4	3	
	M		3	12	11	15	2	7	6	6	1
NUTRITIONAL DISEASES	F					1	1		1		1
	M		1			2	2		1		
TUMOR	F					1			2		
	M					1					
GYN			1		3	1		3	3		
ORTHOPEDIC	F			1					1	1	
	M					6			2		2
SKIN CONDITIONS & INFECTIONS	F	2	6	3	3		2	10	12	5	1
	M		3	2	4	3	3	8	10	4	
T.B. SUSPECTS	F										
	M					3					
RESPIRATORY INFECTIONS	F	4	8			1	13		4	2	
	M	8	10	3	3	8	14	25	6		1
V.D.	F					1					
	M										
TOTALS		28	50	34	53	61	70	113	82	43	12

(NOTE: This Table is Continued on the Next Page)

TABLE I (CONTINUED)

NEGRO

DIAGNOSIS	SEX	0/1	1/5	5/15	15/45	45+	TOTALS (White, Mexican, Negro)
ANXIETY	F		1		1		7
	M						
ARTHRITIS	F					3	5
	M					2	3
CARDIO	F				2	3	12
VASCULAR	M				1	3	10
COMM.	F						5
DISEASES	M				1		19
DENTAL	F						1
	M					2	2
DIABETES	F						2
	M				1		4
E.N.T.	F		2		1	1	33
	M		2	2	1	1	52
EPILEPSY	F				1		4
	M		1				4
G.I.	F	1	1		1		40
	M	1	2		1	1	46
G.U.	F		1				9
	M					1	10
HERNIA	F						
	M		1			1	5
MINOR & MAJOR	F			1	5	5	32
INJURIES	M		1	4	2	9	79
NUTRITIONAL	F						4
DISEASES	M		1				7
TUMOR	F					1	4
	M						1
GYN					3		14
ORTHOPEDIC	F					1	4
	M	2					12
SKIN CONDITIONS	F	2	4	1	1	1	53
& INFECTIONS	M		5	3		1	46
T.B. SUSPECTS	F				1		1
	M			2		3	8
RESPIRATORY	F	2	4				38
INFECTIONS	M	2	5		1	5	91
V.D.	F						1
	M					1	1
TOTALS		10	31	13	24	45	669

TABLE II

SICK PATIENTS TREATED IN CLINIC

AGE IN YEARS	MALE	FEMALE	TOTAL
0 - 1	42	46	88
1 - 4	52	24	76
5 - 14	126	152	278
15 - 44	48	324	372
45 - 64	24	48	72
65 +		1	1
	292	595	887

This does not include:
- Parasite Treatment
- V.D. Treatment
- Tuberculosis Drugs
- Insulin
- Birth Control Pills
- Prophylactic Drugs for Rheumatic Fever

TABLE III

Transportation Furnished to Patients Referred to Clinics Outside the County

	Children	Adults
Number of Trips: 180		
Number to Anti-convulsive clinic................	20	
Number to Cancer Clinic.........................		371
Number to Crippled Children's Clinic............	100	
Number to Council for the Blind.................	27	20
Number to Outpatient Children's Variety.........	18	
Number to Rehabilitation........................		83
Number to U. S. V. A. Hospital..................		5
Number to Dentists..............................	1	
Number to T. B. Hospital........................		4
Number to Cardiac Hospital......................	10	
TOTAL..................	176	483
GRAND TOTAL..................		659

TABLE IV

DENTAL PROGRESS REPORT

October 10, 1966,thru April 30, 1967

(1)	Number of Dental Inspections	2,596
(2)	Number requiring treatment	919
(3)	Number completing treatment	228
(4)	Number admitted to clinic for treatment	429
(5)	Total fillings	1,339
(6)	Total extractions	637
(7)	Total applications of Fluoride	85

TABLE V

OTHER SERVICES PROVIDED

MATERNITY	MIGRANT TOTAL	COUNTY TOTAL
Medical Conference	512	628
Nurses Office Conference	714	832
Nurses Field Visits	136	171
Family Planning	332	378
IUD's Inserted	50	50
BIRTHS	153	485

Hospital Deliveries: Migrants - 133
Midwife Deliveries: Migrants - 20

(13 Collier County patients were delivered by midwife in Lee County)

CHILD HEALTH

	Migrants			County		
	0-1	1-4	5-+	0-1	1-4	5-+
Well Child Conference	61	10	17	82	24	28
Medical Conference	13	10	49	21	17	62
Nurses Office Conference	300	422	691	348	471	888
Nurses Field Visits	85	45	107	109	81	192

NOTE: This Table Does Not Include School Visits

TABLE VI

VOLUNTARY SERVICE

Dr. McCree: 8 Hours, 1 x Month
Other Clinic Volunteer Help: 40 hours per month

Groups assisting with Migrant Health:

(1) Episcopal Church Women:
    5 complete new layettes monthly

(2) United Church Women:
    (a) Money for infant, children, and adult vitamins; approximately $100.00 per year.
    (b) Approximately $150.00 to $200.00 per year for clothing to aid children for school attendance.
    (c) Approximately $1,500.00 contributed towards the upkeep of day care center for migrant children.

(3) Lutheran Church Women:
    Limited amount of layettes and preschool clothing.

(4) An interested women's group donates:
    (a) Clinic patients examining gowns.
    (b) Patient drape sheets.
    (c) Nurse aprons.
    (d) Bibs for day care children.
    (e) Tuberculosis patient robes.
    (f) Two dozen layettes.
    All new material furnished by them; approximately $500.00

(5) Sample medicines given by physicians of Collier County;
    Amount or value undetermined.

(6) County Welfare - Tuberculosis

    (a) Transportation.
    (b) Clothes.
    (c) Hospitals.

(7) Presbyterian Church Senior Class, with assistance of a private physician from the Naples area did 226 physical examinations on migrant preschool and school children, with all defects referred to the health department.

TWO CLIPPINGS FROM SEVERAL NEWSPAPER WRITEUPS REGARDING COLLIER COUNTY MIGRANT HOUSING

MARCH 24, 1967 Collier C. News

Grand Jury Deplores Housing

What were described as health, fire, sanitary and building hazards "in migrant labor camps and so-called hotels or rooming houses throughout the county" were brought to the attention of the public Thursday after the 1967 Spring Term Grand Jury for Collier County had handed its report to Circuit Court Judge Harold S. Smith.

The jury's statement added that "in the Immokalee area conditions were found to be deplorable, with particular reference being made to labor housing."

Saying it had carefully investigated health, sanitary and safety conditions in the county, the jury stated: "..there is a noticeable lack of compliance with licensing laws pertaining to health hazards, fire hazards, sanitary hazards and building hazards."

That law-enforcement agencies are faced with a problem in the situation described was indicated by the jury when it said "state and county authorities engage in a running battle to keep abreast of these problems - involving illiteracy, drinking, filth and poor morals."

Declaring it had no desire to deprive growers of a necessary labor market and that it was aware that there exists a public housing authority to undertake to provide improved housing conditions in the Immokalee area, the jury concluded its report as follows:

"The Grand Jury deplores the fact the County Commissioners have no authority to condemn dangerous structures in the county. It is, therefore, recommended the County Commission obtain the authority from the Florida State Legislature as soon as practicable. It is also recommended that state and county enforcement officers exercise immediate and effective compliance of their respective spheres of jurisdiction to alleviate and remedy these unsatisfactory conditions in Collier County.

Ft. Myers
3/24/67

Health, Fire Hazards Hit By Grand Jury

By FRED WINTER

NAPLES — The grand jury Thursday called for new legislation and strong enforcement of present laws to correct health, fire, sanitary and building hazards.

Its report, filed with Circuit Judge Harold S. Smith, cited no specific examples of hazardous conditions and, named only the Immokalee area as a place where "conditions were found to be deplorable with particular reference being made to labor housing."

The report was signed by Lewis W. Parks, foreman of the 18-man jury, Joseph H. Bishop Jr., vice foreman, and W. H. Kaverman, clerk.

The jury reported it had "examined health, sanitation and safety conditions in the county."

"We now find," the report continued, "that there is a marked laxity in enforcement of applicable statutes, ordinances and administrative regulations, safety and housing conditions in migrant camps and so-called hotels or rooming houses throughout the county."

Lack of Compliance

The jury called several county elected officials and employes during its month-long hearings. Officials said they had no comment on the report.

The report cited a "noticeable lack of compliance with licensing laws pertaining to health hazards, fire hazards, sanitary hazards and building hazards."

In the Immokalee area, it said, "conditions were found to be deplorable with particular reference being made to labor housing."

"Specific instances of violations and irregularities throughout the county have been strenuously brought to the attention of appropriate enforcement officers," the grand jury said.

"State and county authorities engage in a running battle to keep abreast of these problems involving illiteracy, drinking, filth and poor morals."

The report siad that "the grand jury has no desire to deprive the growers of a necessary labor market."

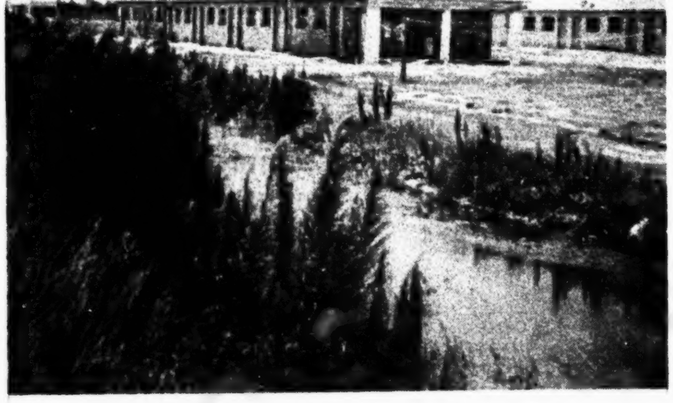
It also took cognizance "of the fact the County Commission has created a public housing authority to undertake to improve housing conditions in the Immokalee area."

"However," the report continues, "the grand jury deplores the fact the county commissioners have no authority to condemn dangerous structures in the county."

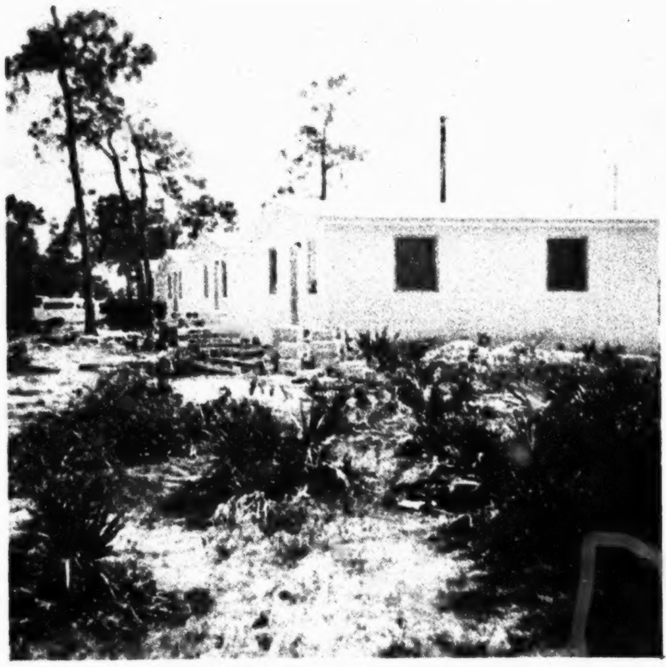
The report recommended:

That "the County Commission obtain the authority from the Florida state Legislature as soon as practicable."

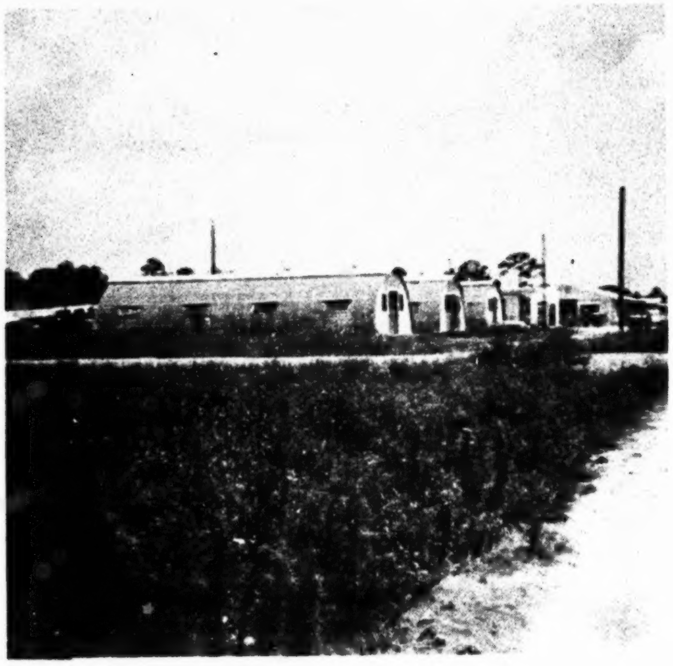
That "state and county enforcement officers exercise immediate and effective compliance of their respective spheres of jurisdiction to alleviate and remedy these unsatisfactory conditions in Collier County."



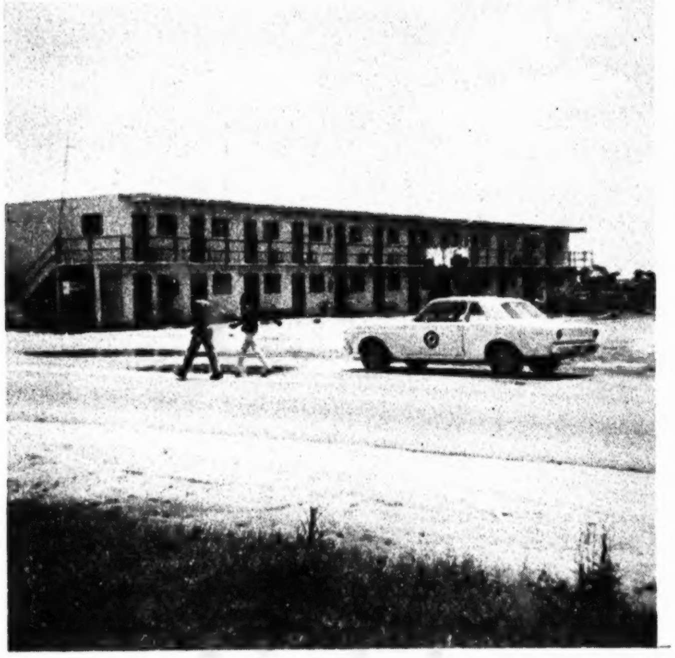
New camp being constructed by Duda Corporation in Collier County. Single story, multi-unit.



Bosso Packing Company Camp now under construction. Individual units.

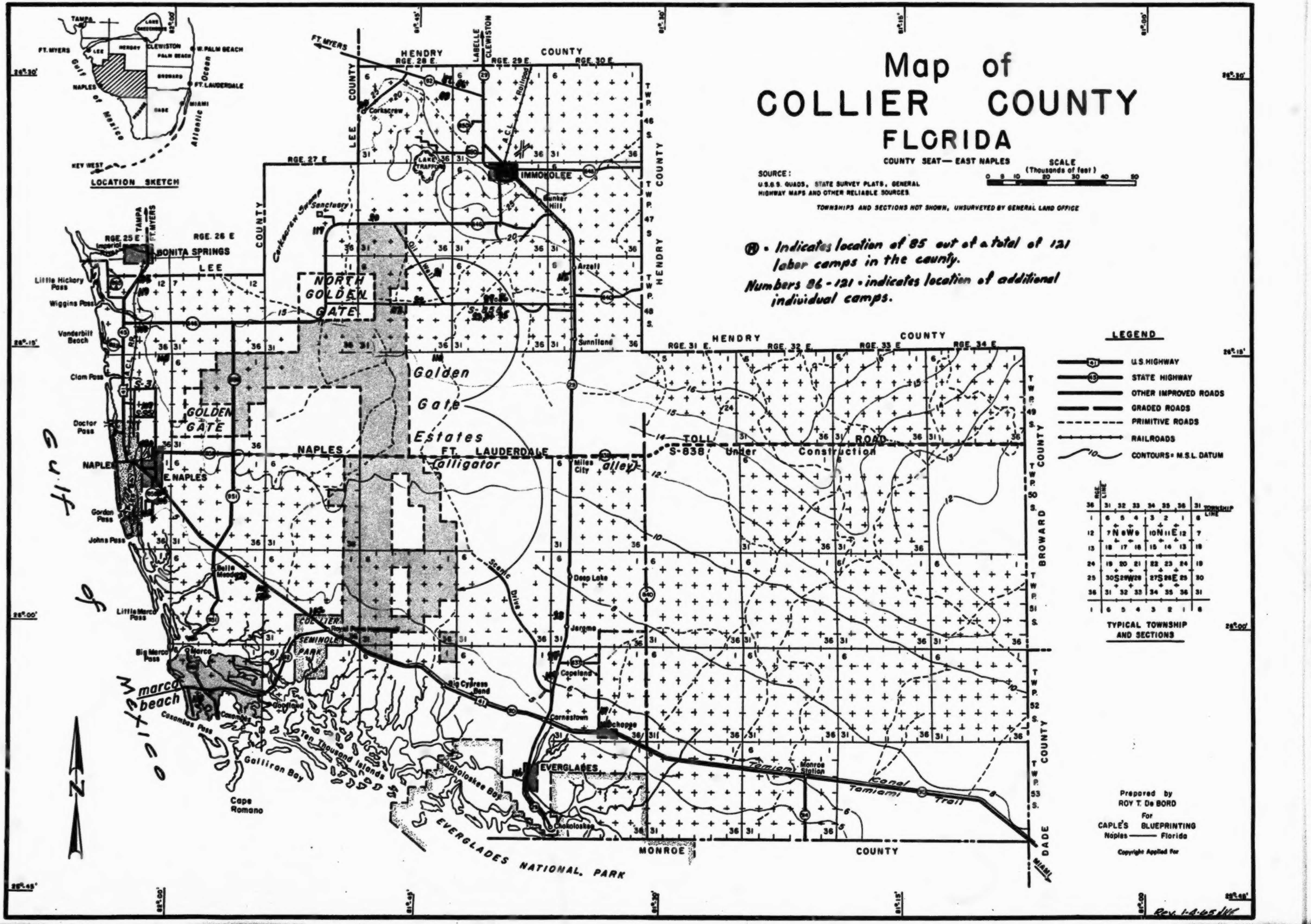


Buddy Carter Camp in Immokalee. Quonset hut type.



RCM Camp. Two story, multi-unit.

VARIOUS TYPES OF MIGRANT LABOR HOUSING IN COLLIER COUNTY



Map of
COLLIER COUNTY
FLORIDA

COUNTY SEAT— EAST NAPLES

SOURCE:
U.S.G.S. QUADS, STATE SURVEY PLATS, GENERAL
HIGHWAY MAPS AND OTHER RELIABLE SOURCES

TOWNSHIPS AND SECTIONS NOT SHOWN, UNSURVEYED BY GENERAL LAND OFFICE

(11) • Indicates location of 85 out of a total of 121 labor camps in the county.

Numbers 86 - 121 • indicates location of additional individual camps.

Prepared by
ROY T. De BORD
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SCALE
(Thousands of feet)
0
5
10
20
30
40
50
LEGEND
U.S. HIGHWAY
STATE HIGHWAY
OTHER IMPROVED ROADS
GRADED ROADS
PRIMITIVE ROADS
RAILROADS
CONTOURS = M.S.L. DATUM
TYPICAL TOWNSHIP AND SECTIONS
LOCATION SKETCH
TAMPA
FT. MYERS
CLEWISTON
W. PALM BEACH
FT. LAUDERDALE
MIAMI
NAPLES
KEY WEST
Gulf of Mexico
Atlantic Ocean
HENDRY COUNTY
LEE COUNTY
BROWARD COUNTY
DADE COUNTY
MONROE COUNTY
RGE. 25 E
RGE. 26 E
RGE. 27 E
RGE. 28 E.
RGE. 29 E.
RGE. 30 E.
RGE. 31 E.
RGE. 32 E.
RGE. 33 E
RGE. 34 E.
TWP. 46 S.
TWP. 47 S.
TWP. 48 S.
TWP. 49 S.
TWP. 50 S.
TWP. 51 S.
TWP. 52 S.
TWP. 53 S.
FT. MYERS
LABELLE
CLEWISTON
TAMPA
Corkscrew
Lake Trafford
IMMOKOLEE
Bunker Hill
Arzell
Sunniland
Corkscrew Swamp Sanctuary
Oil Well
A.C.L. Railroad
BONITA SPRINGS
Imperial
Little Hickory Pass
Wiggins Pass
Vanderbilt Beach
Clam Pass
Doctor Pass
NAPLES
E. NAPLES
Gordon Pass
Johns Pass
Little Marco Pass
Big Marco Pass
Marco
Caxambas
Caxambas Pass
Goodland
Cape Romano
Gulliran Bay
Ten Thousand Islands
Chokoloskee Bay
Chokoloskee
EVERGLADES
EVERGLADES NATIONAL PARK
NORTH GOLDEN GATE
GOLDEN GATE
Golden Gate Estates
NAPLES FT. LAUDERDALE alligator alley
TOLL ROAD S-838 Under Construction
Miles City
Deep Lake
Jerome
Copeland
Carnestown
Ochopee
Monroe Station
Big Cypress Bend
Belle Meade
Royal Palm Hammock
COLLIER SEMINOLE PARK
Scenic Drive
Tamiami Trail
Canal
MIAMI
Gulf of Mexico
marco beach
N

DADE COUNTY DEPARTMENT OF PUBLIC HEALTH

T. E. Cato, M. D., Director

Area of County:	2,054 square miles
Resident Population:	1,124,200
Number of Migrants:	12,000
Migrant Project Staff:	1 Public Health Nurse Super. 4 Public Health Nurses 1 Public Health Physician 1 Sanitation Supervisor 1 Health Educator 1 Lab Technician 1 Clerk-Typist

DADE COUNTY DEPARTMENT OF PUBLIC HEALTH

ANNUAL PROGRESS REPORT ON PUBLIC HEALTH SERVICE GRANT MG-34 D (67)

COMPREHENSIVE HEALTH CARE FOR MIGRANT FARM WORKERS IN DADE COUNTY

I. Introduction and Background Information

This report covers twelve months, beginning June 1, 1966, and it is the fourth such report since this project began on January 1, 1964. The Migrant Health Branch of the U. S. Public Health Service renewed the project on January 1, 1967, and additional funds were allocated for two more public health nurses and a health educator. The following pages will also describe other improvements made possible during the year.

As the Preliminary Report for 1967 indicated, staff vacancies and unusual turnover in personnel hampered the program during the migrant season. Of the five nursing positions, for example, only two were filled during most of the time covered by this report, and these were filled by nurses new to the project. The laboratory technician position and the health education position also remained vacant.

Despite the situation with regard to a shortage of project personnel, a relatively high level of migrant health activity was maintained by the staff of the Dade County Department of Public Health. Family Health Service Clinics were conducted at the four sites established through the project, as well as in the permanent health department centers. Services for migrant preschool and school children were strengthened. A new dental clinic was provided. Improvements were made in the Environmental Health Program. Finally, some funds to support inpatient hospital care were made available to the project in May. The latter action completes the range of health services which the project offers the migrant worker and his family.

An application for continuation of the project has been prepared. No basic changes in the objectives of the program or in operating procedures are proposed. The need for a significant increase in funds for in-patient care is quite apparent. Other project activities can probably be maintained with a very moderage increase in financial support, provided health man-power is available.

II. Domestic Agricultural Migrant Situation in Project Area

A. Number of Migrants at Peak of Crop Season

Our most reliable estimates place the total migrant population at nearly 12,000 persons at the peak of the crop season in January and February of 1967. As previously indicated, our season is from October through May, and growing conditions were mostly favorable during the 1966-1967 season. Table E (appended) presents information about crops grown here.

B. Migrant Camps and Characteristics of the Population

Table A (appended) summarizes the camp data for the 1966-67 season. The project staff gathers this information by canvassing each camp two or three times during the season. Following Table A, there is a schematic map presenting the names and locations of the migrant camps (and the family health service field clinics).

A comparison of camp statistics for the last four seasons reveals the following:

	1966-67	1965-66	1964-65	1963-64
Maximum Census	4,885	4,741	5,732	6,355
Number of Camps	25	26	28	41

We feel that the major factor in the decline in camp population and in number of camps is a continual trend toward private housing and away from camp housing. Some camps were closed because they could not meet licensure requirements, but their closure was not accompanied by corresponding demands for camp housing elsewhere in the vicinity.

Regarding other characteristics of the migrants in camp housing there was a reduction in the number and proportion of American Negroes, an increase, both actual and relative, in the number of migrants of Mexican origin, and the absence of off-shore labor from the British West Indies. We have not noticed other significant changes in the ethnic, age, or sex distribution of the migrant population. These are apparently about the same as reported in our previous reports, as are the sources and travel patterns of the various racial and/or national groups.

III. Project Objectives as Stated in Approved Project Plan

A. The primary objective of this project is to provide a comprehensive and coordinated program of clinical, nursing, and sanitation services to migrant farm workers and their dependents in Dade County.

B. Contributory and secondary objectives include the following:

1. Determination of the health needs of agricultural migrants in this area.
2. Meeting these needs with existing community resources when possible, and filling some of the remaining unmet needs through services provided by this project.
3. Identification of other factors which affect health services for agricultural migrant workers in Dade County.
4. Establishment of standardized records and procedures to facilitate follow-up care through improved interstate and intrastate cooperation and communication.
5. Publication of results which may be deemed useful elsewhere.
6. Affording training opportunities for persons interested in the development of similar activities in other areas.

IV. Family Health Service Field Clinics and Other Outpatient Clinic

A. Family health service field clinics were operated at four locations during the 1966-1967 season with an afternoon clinic conducted at least once a week at each location, except at the Perrine Clinic where the caseload did not warrant afternoon sessions. An evening clinic was conducted at each location at least once a week. The approximate locations of the four clinic sites are indicated on the schematic map depicted in Table B (appended). Table D (appended) summarizes clinic attendance at the four family health service field clinics by month, by location, and by day or evening sessions. It also presents the number of sessions conducted at each location. Comparisons between the 1966-67 family health service clinic caseload and the previous seasons are as follows:

	1966-1967	1965-1966	1964-1965
Age distribution:			
Under one year	255	303	396
1 to 5 years	585	691	681
5 to 15 years	633	811	550
15 to 45 years	1,485	2,094	1,316
45 years older	539	658	467
Ethnic groups:			
Mexican	2,002	1,811	1,879
Negro	885	2,186	1,153
Puerto Rican	475	460	237
White	135	100	141
Sex distribution:			
Male	1,714	2,342	1,717
Female	1,783	2,215	1,693
Total Attendance:	3,497	4,557	3,410
Return Visits:	1,498	2,213	1,510
Seen by physician and nurse:	3,405	4,552	3,366
Seen by nurse only:	92	5	44
Total clinic sessions:	152	268	225

As in preceding years, clinic schedules and related information were widely distributed and publicized throughout the migrant area during the season. The clinics were staffed by the project coordinator, the project physician, project public health nurses and several public health nurses from the generalized program, one clerical worker and volunteer clerical aides when they were available. A total of 135 hours of work were contributed by the latter. As mentioned on the first page, lack of staff hampered the clinic program, and this was one of the main reasons why there was a decrease in the number of patients seen this year compared to 1965-66.

A wide variety of conditions were treated, and the six major categories of complaints are detailed in Table C (appended). Acute upper-respiratory infections continued to be the most common diagnosis, accounting for nearly one-third of the patients seen. In addition to the conditions listed in Table C, genitourinary problems, nutritional disorders, arthritis, psychoneuroses, and diabetes were not uncommon. Maternity patients were referred to regular health department clinics where specialized and more intensive prenatal care could be rendered.

In addition to the above referrals, 89 patients were referred to Kendall Hospital, Jackson Memorial Hospital or Variety Children's Hospital for further diagnosis and possible treatment. Our follow-up information indicates that at least half of these patients kept their appointments. In some cases, the patient's condition was serious enough to warrant immediate admission to the hospital. Patients, or the parents of patients, who failed to keep their appointments usually stated that transportation problems and inconvenient hours were the major reasons, and we observed that those whose symptoms were not acute were least likely to keep their appointments. Approximately 300 children and adults received various immunizations at the family health service field clinics, but patients rarely visited the clinic primarily for this purpose. Funds for inpatient care were approved in May, and such care was authorized for three patients, representing a total of 22 patient-days by the end of that month.

B. Project Dental Clinic

The health department established a permanent dental clinic in Homestead during December. A total of 49 evening dental clinics were conducted, and migrants made 275 visits to this clinic. There were fewer broken appointments than previously experienced, but the dental program was hampered by a delay in the installation of equipment and by the lack of a high-speed drill. Hopefully, the 1967-68 season will witness a substantial improvement in dental services.

C. Migrants Served at Regular Health Department Clinics

In addition to the visits made to the family health service field clinics and to the migrant dental clinic, migrants made 1,199 visits to regular health department clinics conducted at our three public health centers in south Dade County. Maternity care accounted for the majority (778) of these visits. Many of these patients also received family planning services. Child health conferences had 302 visits by migrants, migrants made 50 visits to venereal disease clinics, and 69 visits were made to our tuberculosis clinics.

The annual x-ray survey was conducted with the mobile unit visiting 22 camps and several communities in south Dade. The major reason for the decrease in the number of x-rays was the fact that only one mobile unit was operating in this area during the 1966-67 season, whereas, two units were operating in recent prior years. The following table represents a five year comparison of these surveys:

	1967	1966	1965	1964	1963
No. of x-rays	3,428	4,415	4,796	4,741	3,447
No. of camps	22	23	16	26	32
No. of new TB cases discovered	3	4	4	5	9

D. Migrants Served at Other Clinics

To receive outpatient care and/or emergency services beyond that which could be provided at family health service field clinics or other health department clinics, the project continued to reimburse Kendall Hospital and Jackson Memorial Hospital (both county-operated) for migrant services at an all-inclusive rate of $7.00 per visit. In addition, a few migrants were seen on an out-patient basis at the James Archer Smith Hospital (privately owned) in Homestead, and at Variety Children's Hospital. The total visits to the four facilities during the 1966-67 season was 1,064, compared to 918 such visits during the previous season. When they submit their bills, these hospitals also furnish the project with the following information for each visit: name, address (with sufficient data to reasonably be certain that the patient was a migrant), age, sex, chief complaint, and summary of the treatment rendered. Table F (appended) illustrates the types of conditions treated.

V. Public Health Nursing Services.

During the 1966-67 season, 18 public health nurses provided services for migrant workers and their families as a part of their generalized program. This, of course, was in addition to the efforts of the project public health nurses. A total of 2,217 home visits were completed, and the following table lists the number of home visits by primary reason for the visit:

Communicable disease control	62
Maternity care and child spacing	685
Pre-school health	720
Tuberculosis control	79
Mental health	6
Infant care	381
School health	169
Chronic diseases	59
Miscellaneous acute disease or impairments	56

Regarding the general effectiveness of nursing services, it should be recognized that the public health nurse is the major link between the patient and the various components of the health program. She provides comprehensive health counselling at home, in clinic, in school and at her office. During a single visit, she may discuss a wide variety of health problems even though this visit is only tabulated according to its major purpose.

The following table reflects the age distribution and the ethnic groups served by home visits:

Age Groups	Home Visits	Ethnic Groups	Home Visits
Under 15 years	1,370	Mexican	1,060
15 years to 45 years	747	Negro	705
45 years and older	100	Puerto Rican	236
		White	213

In cooperation with the Florida State Board of Health, and several other states, the public health nurses continued to participate in an experimental referral system. Our experience indicates that the system has considerable merit except in those situations when the migrant is uncertain of his destination or when he goes to a place other than the stated destination, thereby causing the receiving agency to make a useless search.

The personal health record form provided by the Public Health Service has been widely used, and it is particularly valuable where other referral forms cannot be used.

VI. Sanitation Services Related to Migrant Housing and Work Locations

Sanitation services were provided by one sanitarian on a full-time basis and two sanitarians on a part-time basis during the period covered by this report. No volunteers have been involved thus far, and the project staff was unable to initiate the part-time health aide program. One of the major reasons was the failure to develop an acceptable contract or other fiscal mechanism to administer this program. Problems related to recruitment and supervision of the health aides also were encountered. Under O.E.O. auspices, however, community workers are now being trained to function in this area.

General information on the location and population of migrant camps in Dade County is presented elsewhere in this report (See appended Tables A and B). Two of the largest camps, Redlands and South Dade, are planning major renovations. In addition, nearly all camps will undergo extensive repairs during the summer months.

During the period covered by this report, 1,308 inspections were made in the 25 licensed camps and in a number of suspect housing operations. Due to these inspections, the following defects were noted and corrected:

Damaged screens	476
Malfunctioning toilets	150
Dirty kitchen areas	75
Unsatisfactory sleeping areas	10
Unsafe water reports	30
Unsatisfactory garbage areas	20
Unsatisfactory shower areas	50
Overcrowding	28
Mosquito breeding	0
New doors installed	20
New windows installed	12

During the previous year, 1,695 inspections were made resulting in a total of 533 corrections (compared to 871 corrections this season). Five of the largest camps have full-time maintenance crews who strive to repair damaged facilities immediately. As expressed in our previous reports, we feel that there has been a marked improvement in the attitude of the growers, the crew-leaders and the migrants regarding the establishment and maintenance of adequate physical facilities and sanitary practices during recent years.

It should be noted that we do not routinely inspect rental housing in the community, since this is the responsibility of the Florida Hotel and Restaurant Commission and the various housing authorities. Nevertheless, our sanitarians investigate any sanitation complaints in all areas. Many of these situations involve migrants, but we do not tabulate them separately.

VII. Health Education Services

In addition to the individual counselling provided by all of the public health nurses, sanitarians, and other personnel associated with the project, the Director of the health department's Health Education Division worked with local O.E.O. Community Action officials in the conduct of group education programs during the season. The programs consisted of showing films, distributing materials, and conducting presentations in the form of lectures and question-and-answer sessions. The films were selected from the Public Health Service Publication No. 879, Agricultural Migrants, Selected films, and No. 1387, Health Education Films for Seasonal Farm Workers. Several films were also selected from the health department's film library as being suitable to be shown to migrants. A few films were also obtained from voluntary health agencies. The following films were shown in the various labor camps:

"Huffless, Puffless Dragon"
"Time to Quit"
"A Healthier Place to Live"
"Insects as Carriers of Disease"
"Human Reproduction"
"It Must be the Neighbors"
"Alcohol"
"How to have an Accident in the Home"
"Cleanliness Brings Health"

The programs reached over five-hundred migrants in south Dade. The purpose of the program was to enable the migrants to gain an insight into some of the health problems that they are confronted with, as well as general information on a level they could understand. It is felt that those who viewed the films may be motivated to improve their health status as well as that of the community in which they live. A full-time, health education position was created for the project in January, but it could not be filled. Project staff participated in several in-service training activities during the year, and a number of distinguished persons visited the project area, including two United States senators.

VIII. Future Project Development

The outlook for the next season is good. Recruitment of nursing staff has been facilitated by Merit System salary increases, and a proposed increase in the health educator salary range may help to fill this position. There are plans for better clinic facilities in the project area, and the prospect of more support for inpatient care is encouraging. No basic changes in the objectives of the project or in operating procedures are proposed.

DADE COUNTY DEPARTMENT OF PUBLIC HEALTH

SUMMARY OF FOURTH ANNUAL PROGRESS REPORT ON PUBLIC HEALTH SERVICE GRANT MG-34 D
1967

COMPREHENSIVE HEALTH CARE FOR MIGRANT FARM WORKERS IN DADE COUNTY, FLORIDA

The primary objective of this project is to provide a comprehensive and coordinated program of clinical, nursing and sanitation services to migrant farm workers and their dependents in Dade County, and the fourth year of this project began on January 1, 1967. This report covers the period from June 1, 1966 through May 31, 1967. This includes the entire local crop season (October - May). Our estimated peak migrant population was nearly 12,000 with about 5,000 in 25 camps.

Under the project, four family health service field clinics were in operation during the season, conducting 152 sessions. Migrants made 3,497 visits to these clinics, and an additional 1,199 visits to regular health department clinics at our three public health centers in south Dade County. They also made 1,064 visits to the out-patient and emergency clinics at Kendall Hospital, Jackson Memorial, Variety Hospital, and James Archer Smith Hospital.

The health department opened a new health center in Homestead and converted part of the old center into a dental clinic. Migrants made 275 visits for dental care.

The annual x-ray survey included at least 3,428 migrants, and three active cases of tuberculosis were discovered.

In addition to their services at the family health service field clinics, in schools, and at regular health department clinics, public health nurses made 2,217 home visits to migrants. Public health nurses, sanitarians, and other personnel continued their health education activities.

Our sanitarians made 1,308 inspections in migrant camps and they were able to stimulate growers, crew leaders, and migrant workers to make many improvements in the physical facilities and in the environmental health practices they observed.

Only 22 days of in-patient care were provided through the project since funds for hospitalization did not become available until May.

The major problem during the year was the shortage of nurses and turnover in personnel.

Grant expenditures for the twelve months total approximately $60,000.00. An application for continuation of the project has been prepared.

TABLE A

	NAME OF CAMP	POPULATION BY ETHNIC GROUP				TOTAL POP.	
		AN	AW	M	PR		
1.	Bailes Road Labor Camp	21				F	21
2.	Borinquen Farm Labor Center				140	B	140
3.	Bull, C. R. Labor Camp	160	18	30	227	B	435
4.	Campbell Farms Camp - East				265	B	265
5.	Campbell Farms Camp - West	117				B	117
6.	Carpenter's Labor Camp #1	20		39		B	59
7.	Carpenter's Labor Camp #2	7				B	7
8.	Cox, H. L. Labor Camp	56				B	56
9.	Cross, H. D. Farm Labor Camp				26	M	26
10.	Douberly, Everett Labor Camp	40				B	40
11.	Douberley, Emmett Labor Camp	37				B	37
12.	Far South Farm Labor Camp	82		35		B	117
13.	Kendall, Harold Labor Camp	6				M	6
14.	Krome Ave. Farm Housing Center	449	25	768	9	B	1251
15.	Kettles Labor Camp	49				B	49
16.	Mason Algers Labor Camp	34				B	34
17.	Markhams Farm Labor Camp				45	M	45
18.	Pearce Produce Labor Camp #1	95				B	95
19.	Pearce Produce Labor Camp #2	115		41		B	156
20.	Redlands Farm Labor Camp		365	417		F	782
21.	Saunders Labor Camp #1	25				B	25
22.	Saunders Labor Camp #2	65				B	65
23.	South Dade Farm Labor Camp	386		650		B	1036
24.	Williams, Dan Farm Labor Camp	1		19		F	20
25.	Hinman's Labor Camp	4				F	4
	GRAND TOTALS	1769	408	1999	712		4888

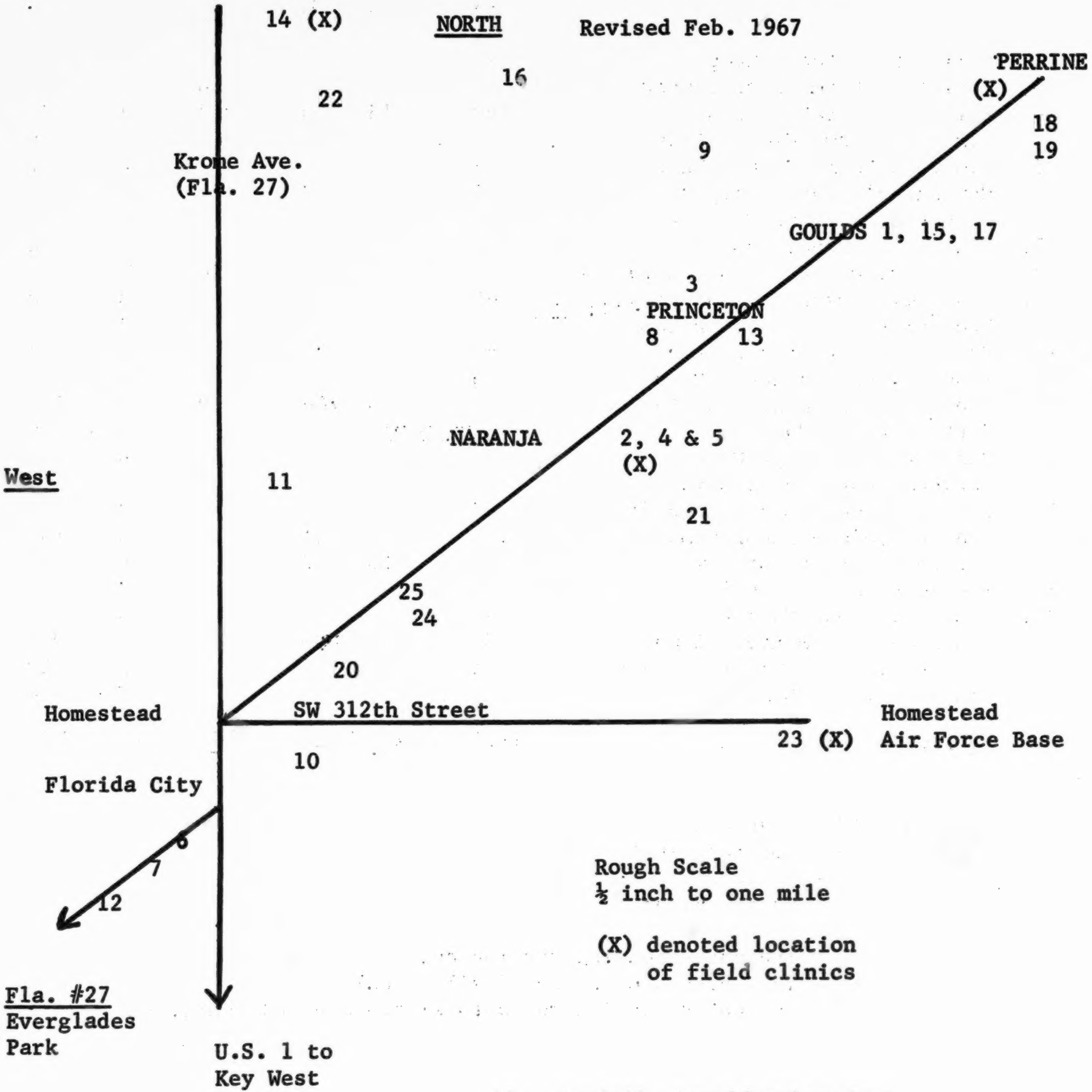
Abbreviations: AN - American Negro
AW - American White
M - Mexican
PR - Puerto Rican

M - Indicates housing for men only
F - Indicates housing for families only
B - Indicates housing for both single men and families

Peak Population in Permitted Migrant Camps in Dade County - 1966-1967 Farm Season

TABLE B

LOCATION OF PERMITTED CAMPS AND FIELD CLINICS FOR THE 1966-67 SEASON


14 (X)
NORTH
Revised Feb. 1967
16
22
PERRINE
(X)
18
19
Krome Ave.
(Fla. 27)
9
GOULDS 1, 15, 17
3
PRINCETON
8
13
NARANJA
2, 4 & 5
(X)
West
11
21
25
24
20
Homestead
SW 312th Street
Homestead
Air Force Base
23 (X)
10
Florida City
6
7
12
Rough Scale
½ inch to one mile
(X) denoted location
of field clinics
Fla. #27
Everglades
Park
U.S. 1 to
Key West

1. Bailes Road Labor Camp
2. Borinquen Farm Labor Center
3. Bull, C. R. Labor Camp.
4. Campbell Farms Labor Camp #1
5. Campbell Farms Labor Camp #2
6. Carpenter's Labor Camp #1
7. Carpenter's Labor Camp #2
8. Cox, H. L. Labor Camp
9. Cross, H. D. Labor Camp
10. Douberly, Everett Labor Camp
11. Douberley, Emmett Labor Camp
12. Far South Labor Camp
13. Kendall, Harold Labor Camp
14. Krome Avenue Farm Housing Center
15. Kettles Labor Camp
16. Mason Algers Labor Camp
17. Markhams Farm Labor Camp
18. Pearce Produce Labor Camp #1
19. Pearce Produce Labor Camp #2
20. Redlands Farm Labor Camp
21. Saunders Labor Camp #1
22. Saunders Labor Camp #2
23. South Dade Farm Labor Camp
24. Williams, Dan Farm Labor Camp
25. Hinman's Labor Camp

TABLE C

	R.I. (1)			G.I. (2)			SKIN (3)			M.I. (4)			ENT (5)			CVD (6)			Nutrition (7)		
AGE	M	F	TOT.	M	F	TOT.	M	F	TOT.	M	F	TOT.	M	F	TOT.	M	F	TOT.	M	F	TOT.
0 - 14	266	259	525	92	82	174	94	132	226	54	53	107	81	53	134	1	1	2	20	31	51
15 - 44	160	152	312	81	62	143	68	41	109	88	51	139	36	37	73	25	63	88	31	41	72
45 +	63	24	87	26	29	55	22	7	29	37	17	54	12	5	17	35	72	107	7	9	16
SUB TOTALS	489	435		199	173		184	180		179	121		129	95		61	136		58	81	
GRAND TOTALS			924			372			364			399			224			197			139

GRAND TOTAL: 2,520

(1) Respiratory infections

(2) Gastrointestinal disturbances

(3) Dermatitis, impetigo, etc.

(4) Minor injuries

(5) Ear, nose and throat

(6) Cardiovascular system

(7) Nutrition

Family health service clinic attendance for seven major categories of medical conditions, by age group and by sex.

NOTE: Format changed from 1965-66 report in accordance with Guide to Preparing Migrant Health Project Reports. Data Sheet 2, Paragraph 4, (Ethnic groups not required)

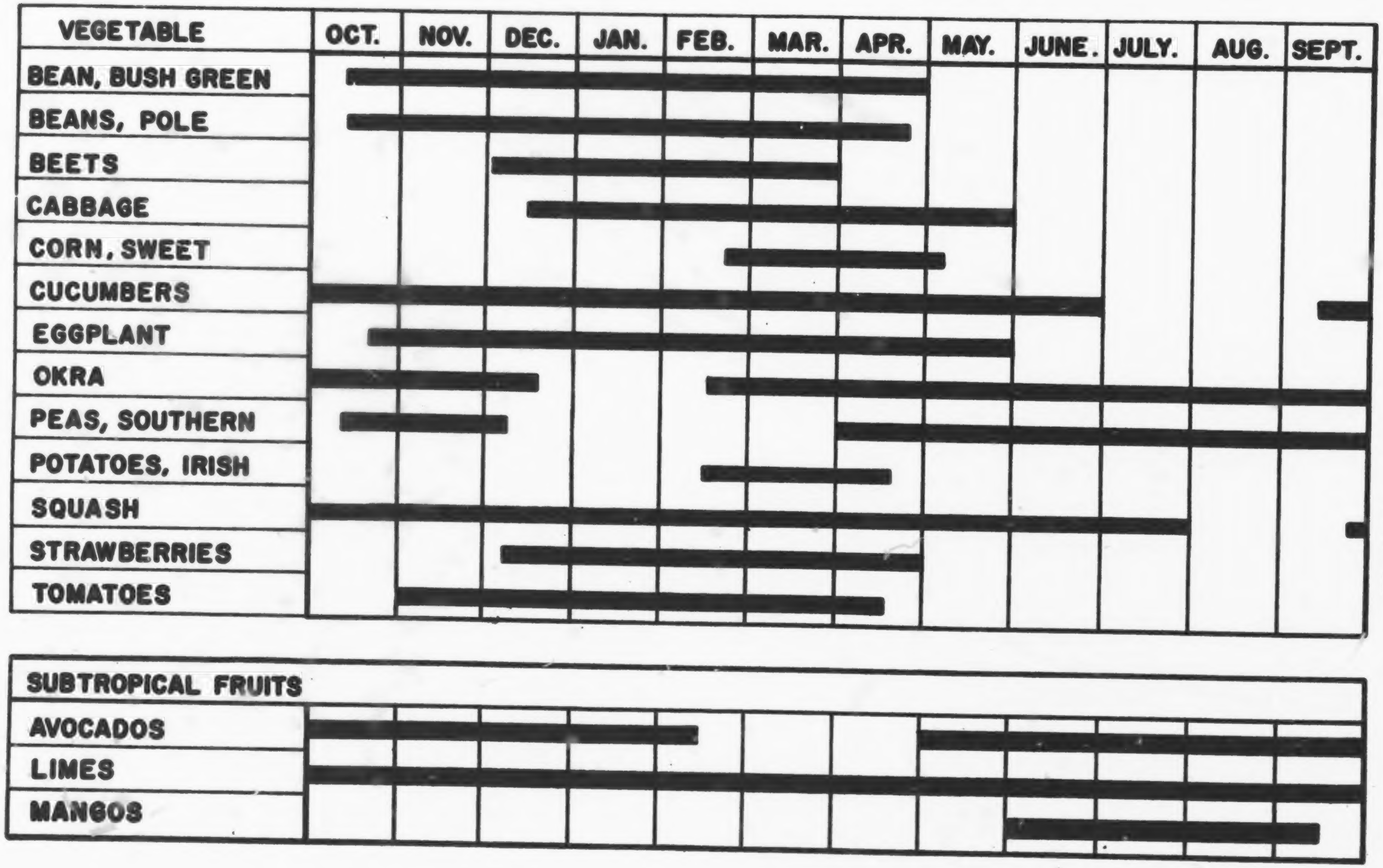
TABLE D

KROME	OCT.		NOV.		DEC.		JAN.		FEB.		MAR.		APRIL		MAY		TOTAL VISITS	TOTAL SESSIONS
	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2		
2-4 p.m.	N/C	0	N/C	0	N/C	0	N/C	0	15	2	55	4	52	5	11	1	133	12
6-8 p.m.	N/C	0	14	1	96	4	167	5	222	4	167	4	135	5	12	1	813	24
TOTAL			14	1	96	4	167	5	237	6	222	8	187	10	23	2	946	36
PERRINE																		
6-8 p.m.	N/C	0	N/C	0	6	1	29	5	65	4	61	4	65	5	15	4	241	23
TOTAL					6	1	29	5	65	4	61	4	65	5	15	4	241	23
SO. DADE																		
2-4 p.m.	N/C	0	N/C	0	N/C	0	43	2	60	4	59	4	103	5	33	4	298	19
6-8 p.m.	11	2	79	4	232	5	261	4	268	4	175	4	217	5	54	5	1297	33
TOTAL	11	2	79	4	232	5	304	6	328	8	234	8	320	10	87	9	1595	52
TALLAHASSEE																		
2-4 p.m.	N/C	0	N/C	0	N/C	0	N/C	0	N/C	0	19	3	20	5	13	3	52	11
6-8 p.m.	7	1	41	4	68	3	113	4	131	4	150	4	115	5	38	5	663	30
TOTAL	7	1	41	4	68	3	113	4	131	4	169	7	135	10	51	8	715	41
GRAND TOTAL	18	3	134	9	402	13	613	20	761	22	686	27	706	35	176	23	3497	152

NOTE:
- (1) Refer to number of patient visits
- (2) Refer to number of clinic sessions
- N/C No clinic

Number of patient visits and number of clinic sessions conducted at the four family health service field clinics during 1966-67 Migrant Season, by month, by location, and by day or evening sessions.

Table E



The year 'round harvest times for fruits and vegetables in Dade County is illustrated by the dark lines on the above chart.

TABLE F

HOSPITAL OUT-PATIENT VISITS BY MIGRANTS

Diagnoses According to International Classification

I.	Infective and Parasitic Diseases	17
II.	Neoplasms	8
III.	Allergic, Endocrine System, Metabolic, and Nutritional Disorders	43
IV.	Disease of the Blood and Blood-Forming Organs	0
V.	Mental, Psychoneurotic, and Personality Disorders	4
VI.	Diseases of the Nervous System and Sense Organs	59
VII.	Disease of the Circulatory System	90
VIII.	Diseases of the Respiratory System	199
IX.	Diseases of the Digestive System	149
X.	Diseases of the Genito-Urinary System	49
XI.	Complications of Pregnancy and the Puerperium	14
XII.	Diseases of the Skin and Cellular Tissue	86
XIII.	Diseases of the Bones and Organs of Movement	51
XIV.	Congenital Malformations	2
XV.	Certain Diseases of Early Infancy	1
XVI.	Symptoms, Senility, and Ill-Defined Conditions	79
XVII.	Accidents, Poisoning, and Violence	213

GLADES, HENDRY & HIGHLANDS COUNTY HEALTH DEPARTMENTS

J. Dillard Workman, M. D., Director

GLADES & HENDRY COUNTIES:

Area of GLADES County:	746 square miles
Resident Population:	3,200
Area of HENDRY County:	1,187 square miles
Resident Population:	10,600
Number of Migrants (Combined):	8,000

HIGHLANDS COUNTY:

Area of County:	1,041 square miles
Resident Population:	22,000
Number of Migrants:	3,500

MIGRANT PROJECT STAFF (COMBINED):

- 2 Public Health Nurses
- 1 Senior Sanitarian
- 1 Public Health Phys.
- 1 Clerk-Typist

GLADES & HENDRY COUNTIES

MIGRANT PROJECT ANNUAL REPORT

May 1, 1966 - April 30, 1967

Efforts on the part of Migrant Project personnel to render health care to seasonal agriculture workers in Glades and Hendry counties were stepped up considerably during the 1966-67 year.

While the statistics for the number of patients' visits to health clinics and for home visits by personnel are impressive (85% increase in first four months of 1967 as compared to similar period in 1966) the plight of the workers and their families remained about the same.

Although one camp installed a shower house, another installed septic tanks for trailers, and several nuisances were eliminated, the general living conditions were unimproved for the most part.

Location and identification of the workers was still an unsolved problem. Loss of project personnel imposed a strain on the work time of non-project personnel in the health department who had to fill in as best they could. The project sanitarian left in December, 1966, and no replacement was found. The departure of the project nurse on January 31 put the burden of her work on other health department nurses whose familiarity with the migrant program fortunately made them able to carry on efficiently. On the less gloomy side, the project was able, through the generosity and cooperation of farm managers, to have a building at each of two labor camps assigned to the health department for migrant clinics. Medical care was extended by the additional funds available this year for equipment and supplies.

OBJECTIVES FOR 1967-68

(1) To continue to improve environmental health aspects of migrants' existence.

(2) To extend health education to migrants.

(3) To compile information on the migrant population through liaison workers.

(4) To inform the general public and certain groups of the project's aims and the migrants' problems.

(5) To extend use of the referral system.

(6) To offer more comprehensive medical and dental treatment to migrants. Many are in need of dental protheses. This is an especially serious problem with young women - not only because of nutritional but also because of cosmetic factors.

(7) To extend family planning services to migrants.

Our plans also include screening programs and health surveys to add to our case finding records for diabetes, tuberculosis, cancer, hypertension, venereal disease, anemia, intestinal parasites, orthopedic and emotional problems.

SITUATION OF DOMESTIC AGRICULTURE WORKERS IN GLADES AND HENDRY COUNTIES

Most of the migrants return to this area in late September or early October and remain until June. Some move to other parts of Florida during the season while others return to Texas or Puerto Rico. The turnover throughout the 8 months season is fairly high, probably around 15% to 20%. The number of day-haul workers in and out of the fields can only be estimated. During the peak of harvesting activity they probably outnumber by several times those who stay for the entire season. The camps are crowded. Farm managers report that more housing could be used but, because of uncertainty of future operations, they are reluctant to invest money in buildings. Some camps are on leased land which the operators say they expect to use not more than a year or two longer. At one camp, however, the manager reported all buildings will be replaced in 1968 or 1969.

Since growers compete among themselves for the labor market, a cooperative housing project for them is out of the question. One manager maintains that the development of a centrally located housing complex, owned and operated by the government, would be the best solution to the problem.

The number of migrant dwellings along highways 29 and 833 south of highway 80 near LaBelle has more than doubled. Last year most of these were under water. Much grading and ditching and culvert installation was done since then which so far has proved unnecessary because of the drought this year. These dwellings are substandard for the most part and have inadequate sanitary facilities, or none at all.

At S & M Camp #2, the housing was reopened this past season. It consisted of a concrete block building divided into rooms by 8-foot high partitions which did not reach the ceiling. It was orignally used as a barracks for 10 single men, and was not used during the 1965-66 season. This year it housed 10 families with over 50 people, including men; women; and children.

The sugar production workers from the British West Indies, as in previous years, lived in dormitories provided by the sugar mills and received their medical care from private contract physicians.

Austin Camp, west of LaBelle, was reopened. Its buildings and facilities are above average.

Most of the Negro migrant workers live in the colored sections of the three cities: LaBelle, Clewiston, and Moore Haven. They are scattered among the permanent and semi-permanent residents of these communities and are difficult to classify occupationally since some of them may migrate a season or two, then remain in the area for several years. Even as late as June, many will say "I haven't decided whether or not I will go north this year." Many are engaged in day-haul work; many move to northern parts of the state for short periods and then return to this area.

Another large segment of the Negro agricultural population lives in camps along the southwest edge of Lake Okeechobee, in Glades County. The housing in these camps is of a better grade than that seen elsewhere for migrants and living conditions are on a higher level.

Personnel: Despite lack of personnel, the staff managed to carry on an active program. The project nurse left her post for work in another county. She was replaced by another part-time public health nurse who increased her hours of work so as to help staff the migrant clinics in the labor camps. She will be replaced by another public health nurse who is receiving orientation now. The position of migrant sanitarian has been vacant since December 15, 1966. The other sanitarians have done his work among the migrants. Clerical services were supplied by non-project health department personnel and by Vista workers.

Vista Workers: Off and on throughout the season the project received help from two Vista workers who lived in the colored section in LaBelle. These young girls did clerical work at clinics; transported patients to and from hospitals, specialty clinics, and health department clinics. They carried out a Vista program among the people in the LaBelle area.

Facilities:

(1) At 6-L's labor camp, the management provided a semiportable building and installed electric wiring and fixtures, partitions, and a screen. A storage cabinet was furnished also by the farm manager. Seats in the waiting room came from those discarded when one of the county buildings was renovated.

A metal cabinet with work top was purchased with migrant funds. Three work tables were acquired from other sources at practically no cost to the project.

At the end of the season, during a heavy wind storm, the walls of the building partially collapsed making it unusable. The grower will repair the building, enlarge it, and add a sink and water connections. Migrant project funds will be used to defray part of the cost.

(2) At Shawnee Farms, a fairly satisfactory building with electric lights, running water, and furniture was made available.

Scales, discarded by another health department facility, were renovated and put to use.

(3) At S & M Camp, changes made are listed in the Sanitation Section of this report. Clinic facilities remained the same.

(4) At Clewiston, a new health department building became available. Although small and crowded it provides excellent facilities for the clinics because of its efficient arrangement.

(5) At LaBelle, unchanged from last season, the fine health department building is adequate.

(6) At Moore Haven, clinics were held at the health department on the second floor of the county building where the space is adequate, but the poor layout makes it undesirable for clinic use. The health department is searching for a better working area elsewhere.

Health Clinics: General family health clinics were provided at the following locations:

(1) Clewiston - Health department building each Monday morning and afternoon. The morning clinic was set aside for Family Planning and prenatal services.

(2) LaBelle - health department building each Thursday afternoon.

(3) Moore Haven - health department in county building each Thursday morning.

(4) S & M Labor Camp - (35 miles south of Clewiston) - each Tuesday afternoon or evening

(5) 6-L's Labor Camp - (6 miles west of S & M Camp) - each Tuesday afternoon or evening, alternating the hours each month with the S & M Clinic.

(6) Shawnee Farms Labor Camp - (7 miles west of Clewiston) - each Wednesday evening.

The clinics were staffed by one to three clerks, one to three nurses, and one physician.

Nurses clinics were held once a week at three labor camps at which time the project nurse visited the homes, gave immunizations, gave family planning and maternity instructions, and advised migrants in matters involving nutrition, baby care, and general health.

A fourth labor camp - Willis - seven miles west of 6-L's - was occupied by migrant workers for a few weeks in the early fall, and for a short period in the late spring. Patients from this camp attended the clinics at 6-L's camp. The nurse visited the camp.

Dental Survey: In March, 1967, a dental survey was made of the migrant camps by a dental hygienist consultant from the Florida State Board of Health.

School Program: Children from migrant families attending public schools received the same health department services as did the other pupils.

Special efforts were made on their behalf to give them every opportunity to obtain the full benefit of the educational and health programs. These included routine physical examinations and vision and hearing tests. The hearing program was extended this year through the initiative and efforts of the Rotary Club of Clewiston to include students in all grades. Attendance at school by migrant children was poor. Several dropped out early in the fall and did not return. Their apathy and language difficulties were the principle reasons. Project personnel made an extended effort with the children and their families to keep the children in school. At Clewiston and at LaBelle special classes were available for the Spanish-speaking pupils. In spite of this, as students drop behind because of last start and interrupted attendance, they soon become aware of the fact that they are among classmates several years their junior. This usually causes embarrassment and reluctance on their part to attend classes. Two children had chronic ear infections associated with hearing loss which added to their difficulties. A deterioration in their ability to speak English was noted as the year wore on.

Tuberculosis Control: Special efforts were made to reach all migrants for chest x-rays and/or skin testing, through use of posters, leaflets, and by word of mouth. With the cooperation of crew leaders, migrants were brought to health department facilities by bus loads at the end of the day for skin testing. Positive reactors were started on prophylactic medication, and had diagnostic (14 by 17) chest x-rays. Through this procedure many persons were screened who had failed to get chest x-rays when the mobile unit was in our area.

SANITATION REPORT

The sanitation activities were carried out by the two non-project sanitarians in the health department. Numerous inspections and investigations were made, many centering on the dwellings springing up along the highway near LaBelle.

S & M Camp #2 - The following improvements were completed:

(1) Six-hundred square feet of drain field (all new construction) was added to the existing septic tank.

(2) Four-hundred square feet of drain field (all new material) was added to another septic tank.

(3) A third septic tank was removed due to its close proximity to the water system.

All of the above systems were thoroughly pumped and cleaned.

(4) All needed window glass and screens were repaired in all buildings.

(5) All screen doors have been replaced where needed or rescreened.

(6) All soil lines were derooted and cleaned.

(7) Men's and women's toilet facilities were expanded.

(8) Approved covered garbage cans were purchased.

(9) Outside wash tubs were removed and entirely new and complete laundry facilities were installed in the former dining area.

(10) A complete regular spraying program for the premises was initiated.

(11) Installation of positive feed hypochlorinators was recommended but have not, as yet, been installed.

S & M Camp #3 -

(1) Two trailers and the restaurant facilities were connected to an entirely new septic tank system. Drain fields were properly fenced.

(2) Impervious vinyl flooring was installed in the kitchen.

(3) A hot water system was installed in the kitchen.

(4) Health cards were secured for all kitchen help.

(5) Illegal sewage lines were removed.

(6) The well was repaired and sealed.

(7) An additional septic tank system was installed for the trailer occupied by the camp manager.

(8) A positive feed hypochlorinator was installed but is not completely operative.

A high degree of water contamination continues. (Camps are in need of intelligent attendants for proper maintenance of equipment.) The farm superintendent was informed of the water condition and advised to take corrective measures.

These improvements are the first phase of a sanitation program which is expected to qualify camps for continued operation.

A new county zoning bill which presumably will be passed at this session of the legislature, plus the extension of powers of county governments to include such things as dog pounds, garbage dumps, flood relief in non-urban areas of the counties, should give the health department new implements with which to cope with the problem of stray dogs left behind at camps, and with many other environmental health hazards.

SUMMARY

Personal and environmental health care was provided for migrant agricultural workers and their dependents in the project area by:

(1) Clinics at health department buildings and at labor camps.

(2) Home visits by nurses and a public health physician.

(3) Referrals to private physicians, dentists, hospitals, tuberculosis sanitariums, orthopedic, tumor and eye clinics.

(4) Screening projects including:

  (a) Dental

  (b) Vision

  (c) Hearing

  (d) Tuberculosis

(5) Sanitarian services.

(6) Nutritionist consultations.

(7) School health programs.

At the six clinics, 317 sessions were held with staff time totaling 941 hours. During this time 2,832 patient visits were recorded.

The largest single reason for a visit was immunization; with maternity care, respiratory infections, skin problems, tuberculosis (tracking down contacts), and family planning, following in that order. Other conditions cared for ran the gamut of human illnesses.

In spite of continued substandard living conditions, the general health of migrant workers remained good. Most of them have learned how to use the medical and dental resources of the community. They appeared to have little reluctance in seeking help. There is a great need for extension of dental services to include protheses in certain selected cases. Hospitalization expenses fell heavily on some of the families.

Cooperation of farm managers was good. They provided more facilities for health workers and seemed to welcome them into their farms and labor camps. Our most serious problem was retaining health department personnel on the project. We are faced with the vacancy in the sanitarian position and probably will lose a nurse. We had to turn down a request to establish a health clinic at one labor camp.

It appears that the migrants appreciate what is done for them, and for the most part, know where to obtain health care when they travel to northern states.

TABLE I

PATIENTS SEEN AT CLINICS

	Clewiston	LaBelle	Moore Haven	S & M	6-L's	Shawnee	TOTAL
Nurse	147	359	517	305	124	199	1561
Nurse & Doctor	11	188	131	415	255	181	1181
Total	158	547	648	670	379	480	2832

TABLE II

PATIENTS SEEN BY MONTHS

	Nurse	Nurse & Doctor	TOTAL
May, 1966	192	142	334
June, 1966	97	32	129
July, 1966	44	20	64
Aug. & Sept., 1966	85	36	121
October, 1966	68	117	185
November, 1966	159	179	338
December, 1966	190	141	331
January, 1967	217	162	379
February, 1967	191	114	305
March, 1967	217	143	360
April, 1967	191	95	286
Total	1651	1181	(*) 2832

(*) Includes 526 home visits

TABLE III

CLINICS HELD

Nurses alone	109
Nurse & Doctor	208
Total	317
Total Hours	941

TABLE IV

PATIENTS SEEN BY AGE/SEX DISTRIBUTION

	Under 15	15 to 44	45 and Over	TOTAL
Male	806	191	86	1083
Female	864	772	113	1749
Total	1670	963	199	2832

TABLE V

PATIENTS SEEN - 1966 COMPARED WITH 1967 (Jan.-Apr.)

	1966	1967
Nurse	451	816
Nurse & Doctor	323	514
TOTAL	774	1313

Note: Clinic census the first four months of 1967 ran 85 per cent heavier than for the corresponding period of 1966.

TABLE VI

CLINIC PROBLEMS

(1)	Immunizations	870
(2)	Maternity	317
(3)	U.R.I.	264
(4)	Dermatitis	201
(5)	Tuberculosis	(*) 149
(6)	Family Planning	134
(7)	Eye, Ears, Nose & Throat	113
(8)	Trauma	96
(9)	Gastro-intestinal	79
(10)	Intestinal parasites	64
(11)	Dental	55
(12)	Neuro-psych.	54
(13)	Infant check	52
(14)	G. U.	36
(15)	Cardio-vascular	34
(16)	Diabetes	31
(17)	GYN	27
(18)	Orthopedic	25
(19)	Tumor	17
(20)	Surgical	16
(21)	Venereal Disease	16
(22)	Arthritis	16
(23)	Contagious (Other)	6
(24)	Allergy	3
(25)	Miscellaneous	143

(*) Includes contacts investigated, chest x-rays, and skin tests

TABLE VII

REFERRALS

Private Physicians	76 (*A)
Florida Council for the Blind	9
Tuberculosis Hospital	2
Crippled Children's Clinic	10
Tumor Clinic	6
Venereal Disease	4
Dentist	31 (*B)
Vocational Rehabilitation	14
Mental Health	2
General Hospital	3
TOTAL	157

NOTE: Differences between figures in Table VII and Table VIII are accounted for by:

* A - Migrants who returned for follow-up and/or went to physician without referral;
* B - Some migrants failed to keep their dental appointments.

TABLE VIII

MIGRANT PATIENTS' CARE

	By Private Physicians	At Hospital (Out-Patients)	By Dentists	Prescriptions
May, 1966	38	9	1	14
June, 1966	15	4	1	21
July, 1966	9	1	2	
August, 1966	7	5	6	6
September, 1966	39	1		14
October, 1966	7	1		27
November, 1966	64	3	8	33
December, 1966	57	2		22
January, 1967	19	4		19
February, 1967	18	2	1	36
March, 1967	14	5	3	26
April, 1967	13	26	3	25
	300 (*A)	63	25(*B)	243

TABLE IX

MIGRANTS' CHEST X-RAY (70 mm)

Shawnee Farms	38
Benbow Farms	100
Click Farms	77
Glades Co-op Sugar Mill	240
6-L's Labor Camp	25
S & M Camp #3	99
S & M Camp #1	20
Clewiston:	
Slim Mabry's	30
Claudie Mae's	154
Spencer's Market	27
Kelley's Market	92
TOTAL	902

Fifteen of these had follow-up 14 by 17 chest x-rays.

TABLE X

ADDITIONAL DATA

FROM ROUTINE HEALTH DEPT. ACTIVITIES REPORTS FOR MIGRANTS

	VISITS	OFFICE	OTHER ACTIVITIES
A. COMMUNICABLE DISEASE			
Immunizations Completed			757
Boosters & Revaccinations			200
Treatment for Parasites			37
B. VENEREAL DISEASE	36	13	
New Cases - 2			
C. TUBERCULOSIS	78	38	
Active Cases			6
Suspects Processed			73
Tuberculin Tests			111
Patients Hospitalized			6
D. MATERNITY	96	257	
Patients			85
Attendance at Pl. Parent. Class			173
E. CHILD HEALTH	182	540	
F. SCHOOL HEALTH (# EXAMINED)			103
Nurse - Teacher Conf.			11
G. DENTAL EXAMINATIONS			242
H. CHRONIC DISEASE			
Cancer	32	9	
Diabetes	6	16	
Cardio-Vascular	8	22	
Cervical Cytology			40
Other	43	119	
J. MENTAL HEALTH	1	4	
K. MISCELLANEOUS	48	304	

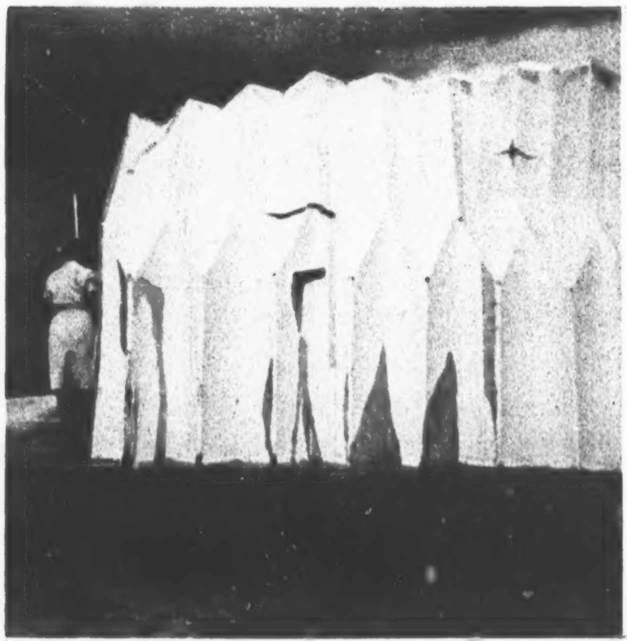
V. **HEALTH EDUCATION** (Sessions attended, talks given)

Doctor - 12

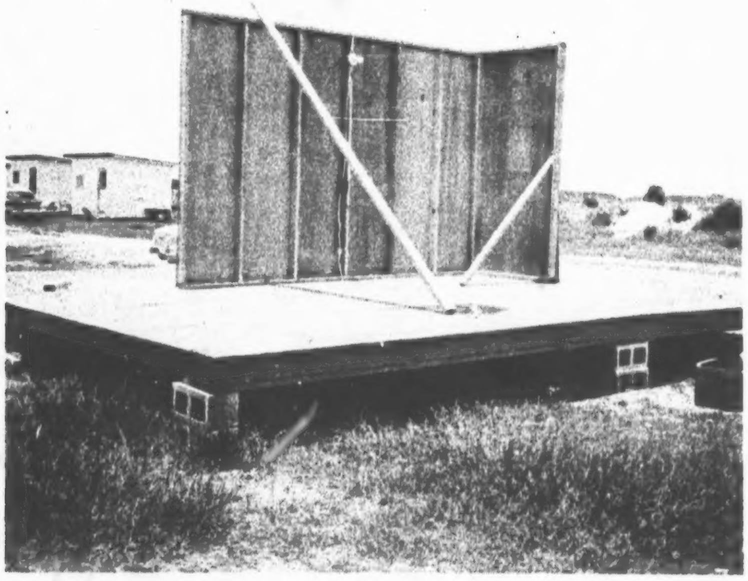
Nurse - 16

Sanitarian - 39

X. LABORATORY	Serology	233	Enteric	63	Urinalysis	263
	RH	51	Gluc.	22	Dextrostix	18
	Hemo.	67	TBC	3	G.C.	8



6-L's Camp tent clinic before storm in Hendry County.

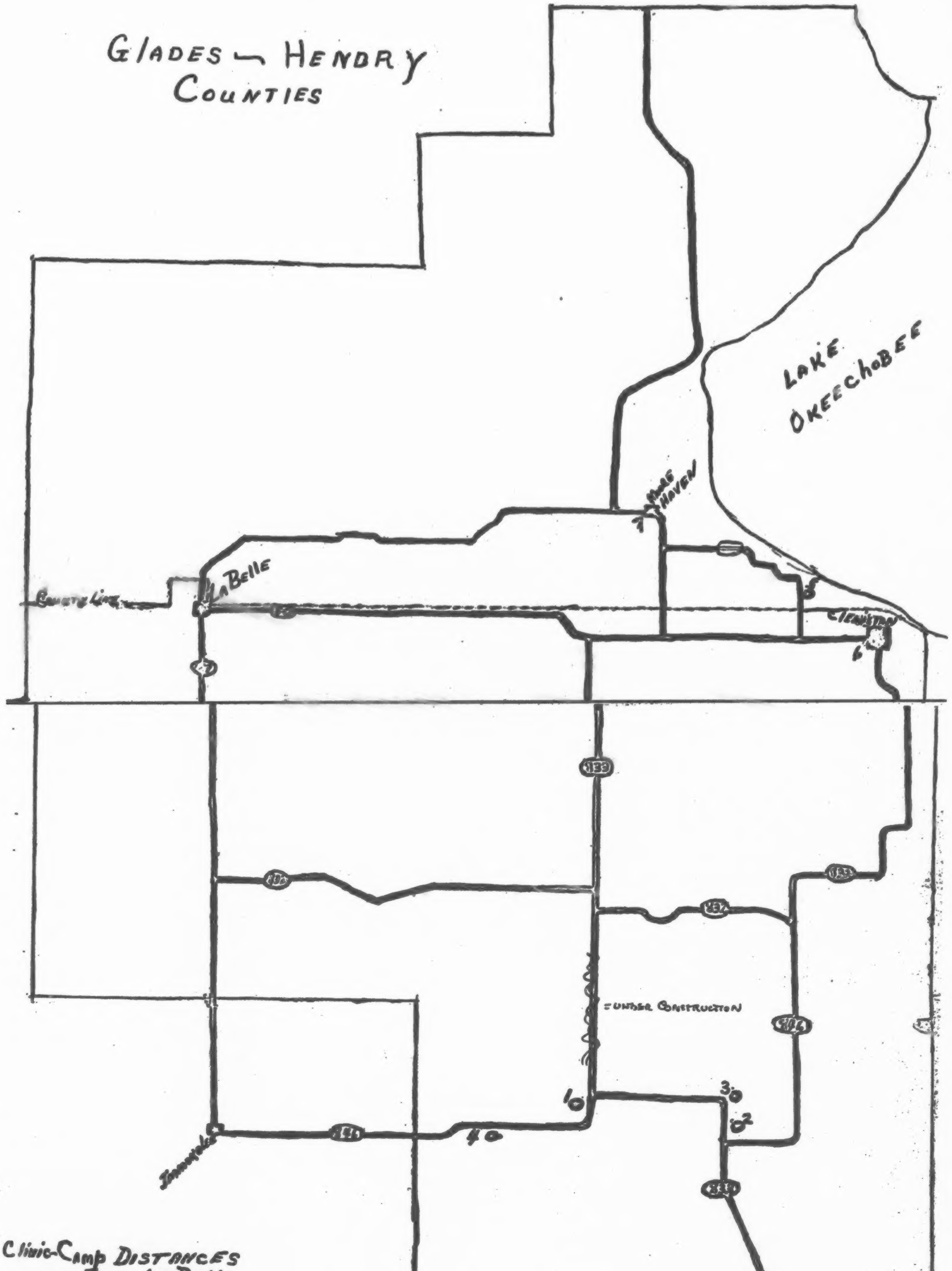


6-L's Camp tent clinic after storm in Hendry County.

Outside water, Hendry County.

Shawnee Farms clinic building in Glades County.

GLADES — HENDRY COUNTIES


LAKE OKEECHOBEE
MOORE HAVEN
7
5
CLEWISTON
6
COUNTY LINE
LaBelle
UNDER CONSTRUCTION
1
3
2
4
Immokalee

Clinic-Camp DISTANCES FROM La Belle

1-6 L's	45 mi
2- S+M #2	52 "
3- S+M #3	51 "
4- Willis	39
5- SHAWNEE	30
6- CLEWISTON	33
7- MOORE HAVEN	25

MIGRANT HEALTH PROJECT

ANNUAL REPORT

HIGHLANDS COUNTY

The number of migrants seems to be the same in Highlands County with some increase each year and a longer stay period of the in-migrants. A large number consider this home and become out-migrants after the citrus and vegetable crops are handled. We have discovered that many in-migrants of previous years are now making, or planning to make, this their permanent base with the bread-winner moving out during the summer to follow the crops. Their main pattern of migration remains the same with an apparent increase in those going to Michigan. The main pattern still remains the Carolinas, the eastern shore, and New York state.

The in-migrants generally come from the southern states with a few off-shore in citrus and some from New York and Pennsylvania. There has been no change in ethnicity of the agricultural workers as they are predominately Negro.

There are now two (2) daycare centers in Avon Park, the average number of children being 90. There is one (1) in Lake Placid with 42 children and one (1) in Sebring with fifty (50) children. Physical examinations by the health department are made and frequent visits are made to centers and homes by nursing and sanitation personnel.

The Housing Authority of Avon Park has the land, but as yet, has not started construction of the proposed low-cost housing units.

More citrus is being planted each year and some increase in vegetable acreage is evident. Due to this, we feel this program will continue to expand from year to year.

One of the main problems for Highlands County seems to be identifying the migrants. Our aim is to assist them in getting the medical care they need. We hope to achieve this by the implementation of the In-Patient Hospital Care Program. Our nurses will follow-up on necessary care for the migrant.

MIGRANT REPORT

At the height of the migrant season we estimate that there are approximately 3,500 migrants in Highlands County. This number includes both the migrant laborers and their families. We have no way to actually total our migrants because we have no migrant camps, as such, and these people live among the general population. We keep a special watch for those residences which begin to fill up during harvest time, and we experience a definite extra load in our clinics during this time. Since last July, our nursing staff has had a vacancy. This has made it quite difficult to render adequate services. Another problem we have encountered in this county stems from the large number of migrants who live in our county but work out of the county. This makes it difficult for them to receive the services available to them because they leave before dawn and return late at night.

In our county we have three general clinics. These are attended by not only migrants but also the general population.

SEBRING	COURTHOUSE ANNEX 9:00 a.m. - 11:30 a.m. 1:00 p.m. - 4:00 p.m.	TUESDAY
AVON PARK	CITY HALL 9:00 a.m. - 11:30 a.m.	WEDNESDAY
LAKE PLACID	CREEL BUILDING (Lake Placid Court House) 1:00 p.m. - 3:30 p.m.	WEDNESDAY

These clinics are attended by a physician, the nurse for that specific area, and a clerk. During the last few months it has been necessary for us to staff the clinics with two nurses due to the large number of people attending. Just recently we moved into the new clinic facilities in the Creel Building in Lake Placid. All the needed equipment is not available as of yet, but the clinic has been serving a larger number of people than ever before.

Transportation has been a major problem for our migrants, as most of the agencies to which we refer patients are at least 60 miles away. Our intrauterine device clinic is held in Sebring and those patients in the outlying areas experience difficulty in finding transportation to it. The future is looking brighter, however, for one of our local churches is organizing a motor pool and has already transported some of our patients to Florida Crippled Children's Commission in Lakeland. Also the local Red Cross Chapter has had a station wagon donated to them and they are also in the process of organizing volunteers. With these two sources to work with we hope to be able to provide a wider range of services for our migrants and to enlarge our intrauterine device clinics.

Our IUD clinic which was set up last summer has been fairly successful. We have had a total of 61 insertions with a number of these being migrants. We are in the process of changing the type of device used with the hope that we will have greater success. We have had two migrant women with IUD's coming to us from other areas wanting check-ups, and one requested that her's be removed.

We have had a measles vaccine campaign and as a result have been doing a booming business with the measles vaccine. We held two measles vaccine immunization clinics, one in the Negro day care center in Sebring and one in the Negro day care center in Avon Park with the resultant vaccination of 110 children.

Plans are in the making for a year round Headstart Program in our county. This would help to eliminate the problem of migrant parents leaving their children at home with no supervision. We are doing all we can to help this grogram get started for it would be a tremendous help to the general population as well as to our migrants.

Currently we are also working on plans for receiving the Migrant Hospitalization Grant. We hope to receive this in the near future for it will be of great benefit to our migrants.

Since our greatest problem is identifying our migrants, our staff is making a sincere effort to seek out and find them. In all our clinics and in the field, we quiz all patients as to migration status hoping to identify them and make them aware of the services available to them.

COMPLETED MIGRANT IMMUNIZATIONS

IN

HIGHLANDS COUNTY

	DPT	POLIO (ORAL)	DT	SMALLPOX	TYPHOID
Under One Year	6	3	0	0	0
One to Four	5	5	0	0	0
Five & Older	3	1	2	1	4
Boosters	5	1	3	0	0

May 1, 1966 - April 30, 1967

FAMILY HEALTH SERVICES CLINICS

AND NURSING SERVICES

HIGHLANDS COUNTY

TYPE OF CLINIC	SESSIONS	HOURS IN CLINIC	PATIENT VISITS	ESTIMATED COST
GENERAL CLINICS				
Nursing	208	834	207	$2,085.00
Medical	155	154	83	4,500.00
Dental		360	400	1,260.00
TOTAL	363	1348	690	$7,845.00

	MAY	JUNE	JULY	AUG.	SEP.	OCT.	NOV.	DEC.	JAN.	FEB.	MARCH	APRIL	TOTAL
Communicable Diseases													
Home Visit	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinic Visit	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity & Planned Parenthood													
Home Visit	0	1	0	0	0	0	0	1	0	0	0	0	2
Clinic Visit	2	7	1	1	0	0	2	3	1	2	6	6	31
Child Health Services													
Home Visit	2	0	0	1	0	0	0	0	1	1	0	0	5
Clinic Visit	0	1	1	0	0	0	1	1	0	2	1	1	8
School Health Services													
Home Visit	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinic Visit	0	0	0	0	0	0	0	0	0	47	0	0	47
Tuberculosis Control													
Home Visit	1	0	0	0	0	0	1	0	0	1	1	0	4
Clinic Visit	0	2	0	0	0	0	0	0	1	4	2	0	9
Morbidity													
Home Visit	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinic Visit	7	1	0	0	0	1	1	1	0	0	0	0	11
Chronic Disease													
Home Visit	0	0	0	0	0	0	0	0	0	0	0	1	1
Clinic Visit	0	1	0	0	0	0	0	1	0	0	0	2	4
Venereal Disease													
Home Visit	0	0	0	0	0	0	0	10	0	0	0	1	11
Clinic Visit	0	1	2	0	0	0	10	6	5	0	5	0	29

NURSING SERVICES BY MONTH AND TYPE

SANITATION

There are four labor camps in the Avon Park area, three of them owned by Manning Kirkland of Avon Park, and one formerly owned by Willie Connell (deceased) of Avon Park.

One of the camps owned by Mr. Kirkland will accommodate 80 and is operating at full capacity at this time. It is occupied by British West Indies workers. One of the other camps is a family-type dwelling and will accommodate 20. It is sub-leased and is in operation. The two camps are in fair condition. The third building is in bad condition and has been condemned by this department. The building owned by Mr. Connell also has been condemned and is not in use.

In the Sebring area a new, modern type concrete block building with modern kitchen, tile baths, and dining room has been built by Sebring Packing Company. This building is also on city sewers. It will accommodate 50 and is operating at full capacity at this time, being occupied by British West Indies workers. There was another labor camp in the Sebring area, owned by Withers and Harshman, but due to lack of off-shore labor, this camp was converted into apartments. This also was a very modern camp.

There is one modern labor camp in the Lake Placid area owned by Consolidated Financial Corporation. This concrete block building is divided into four rooms, which will house 10 persons per room, with one room for the camp manager. There are about 15 laborers in the camp at this time.

A new labor camp is expected to be built this year in the Lake Placid area by Nathaniel Hawthorne. This camp will accommodate 40 persons when completed.

Highlands County is a citrus producing county so consequently, most of the migrants here are fruit pickers. The fruit season runs from November through July. Several camps have closed over the past several years due to the cut-back in the use of off-shore labor.

LEE COUNTY HEALTH DEPARTMENT

Joseph W. Lawrence, M. D., Director

Area of County: 786 square miles

Resident Population: 70,000

Number of Migrants: 10,625

Migrant Project Staff:
- 2 Public Health Nurses
- 1 Sanitarian
- 1 Clerk-Typist

LEE COUNTY

ANNUAL PROGRESS REPORT

(May 1, 1966 through April 30, 1967)

Lee County experienced an increase in seasonal agricultural workers during this report year. An estimated 10,625 migrants were in Lee County during the peak of the growing season. Based on figures from agricultural and Farm Bureau sources, there were 4,250 workers and their 6,375 dependents (children and relatives). Many of the migrants living in Lee County this year worked on the farms in the Naples area of Collier County. They traveled by labor busses to the harvest area.

More workers were needed. Because of an unusually mild winter, crops of tomatoes, squash, corn, peppers, watermelons, and flowers were harvested in amounts far above the previous year. Citrus growers planted 1,400 acres of new trees. Flower growers showed increased production. Enough seasonal workers were on hand to harvest the vegetables and flowers, but more were needed to finish picking and packing the citrus fruit.

Sixty-seven per cent of our migrant population are Negroes from the bordering states of Alabama and Georgia and some consider the Carolinas as home. Seven and six-tenths per cent are Texas-Mexicans and 22.7 per cent are Puerto Rican. (One grower alone brought in 35 single males directly from Puerto Rica to work on his farm.) Two and seven-tenths per cent are White and come from New York and New Jersey. The Anglos usually find work in packing houses while in this area.

The majority of the migrants arrive in September and depart late in May. Because many stay eight or nine months, they consider Lee County their home base. Father, mother, and older children may follow the stream, leaving younger children with relatives. Other times, father and the older children may go north while the mother maintains a home here. A few pay rent on living units the year round and return to the same locations in the fall. We estimate a 1,000+ migrant population in the summer.

This year referrals were sent to Beauford and Charleston Counties in South Carolina; Brevard and Faison Counties in North Carolina; Tupelo in Mississippi; Harkness and Brownville in Texas. Referrals were also sent to Ohio, New Jersey, and Michigan. These were requests for follow-up on family planning, infant and preschool, T.B. and V.D., etc.

The close working relationship between the sanitarian and the nurses coordinated family health services in clinics and camps. This made possible a consolidation of information presented in this narrative and tables. Of the six scheduled clinics - all but two are held in migrant camps.

CLINICS

Locations and Facilities Used

(1) HARLEM HEIGHTS: This clinic is in a labor camp sixteen miles south of

8

Fort Myers. Clinics are held each Tuesday from 1:00 p.m. to 10:00 p.m.

1:00 p.m. to 5:00 p.m. - Nurses
5:00 p.m. to 10:00 p.m. - Doctor and Nurses

This is a well equipped clinic, consisting of two small rooms 8 by 10 with bath rooms. This clinic has been so well attended in the past year that another room has been made available for use as a waiting room and for registering patients. Shelves have been built, each room freshly painted, and new and needed equipment purchased.

(2) TEETER ROAD: A stationary trailer is used for this clinic, also located in a labor camp, seven miles south east of Fort Myers. Clinics are held on alternate Monday mornings and Thursday nights.

9:00 a.m. to 12:00 noon - Nurse
7:00 p.m. to 10:00 p.m. - Doctor and Nurses

These facilities are inadequate because of the lack of a bath room and waiting space. Since most of the migrants who populate this camp leave in May, the doctor's clinic is discontinued in the summer.

We hope to lease and renovate a house in this camp. This will add much to the efficiency of the clinic.

(3) JONES WALKER: This clinic is located in an old hospital building in the Negro section of Ft. Myers. The Lee County School Board donated one room to us for use as a clinic. We made an extremely slow start. After three months, however, more room was needed - and added - equipment purchased, and an extra room is presently being readied for use. Monday nights: 7:00 p.m. to 10:00 p.m. - Dcotor and Nurses

(4) CHARLESTON PARK: Is located in Alva, twenty miles east of Fort Myers. Clinics are held alternately, Thursday mornings.

9:00 a.m. to 12:00 noon - Nurse

This clinic is still being held in a camp owner's car port and with no facilities. Much needed work is not done, but plans are being made to move the trailer from Teeter Road to this all-Negro camp. When this is done a generalized clinic - with all services - can be offered. Two Vista workers live in this camp and gave some assistance.

(5) ORANGE GROVE COURT: Is in Estero, fourteen miles from Fort Myers. Clinics are held one morning a month.

This new camp was opened in January by Collier County Growers. The clinic was set up in a laundry room for immunizations of the children. No other service was given as most adults worked daily.

Services offered in clinics by nurses include prenatal care, infant and child care, child spacing, diabetic screening, tuberculosis screening and follow-up, immunizations, health education by the nurses. Migrant mothers and children are encouraged to attend day clinics, leaving night clinics free for adult workers.

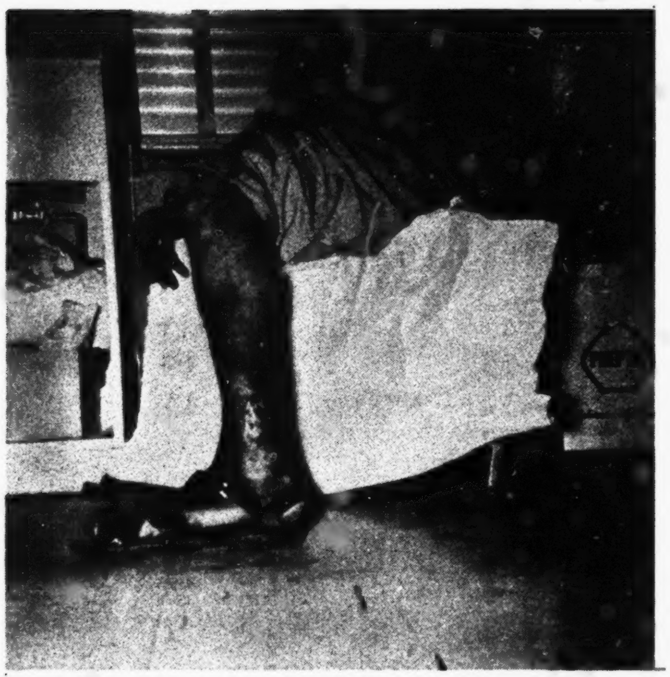
Doctors' clinics offered generalized comprehensive medical service. There are three public health nurses who serve in these clinics. One is paid by Project funds, one by Maternal and Child Health, and the other is on the health department staff. There are three doctors paid from the migrant budget. The half-time clerical position has been changed to full-time and this clerk will also work in these clinics. Health department staff nurses assist when needed, especially during the peak season.

(6) **LEE COUNTY HEALTH DEPARTMENT**: Third floor, Lee County Court House

X-ray - every day -	8:00 a.m. to 11:00 a.m. 1:00 p.m. to 4:00 p.m.	
Monday	8:00 a.m. to 11:00 a.m.	General Medical & Immunization
"	1:00 p.m. to 4:00 p.m.	Maternity
Tuesday	8:00 a.m. to 5:00 p.m.	X-ray, V.D., Health Cards
Wednesday	8:00 a.m. to 11:00 a.m.	Medical Maternity
"	1:00 p.m. to 3:00 p.m.	Cytology Clinic
Thursday	1:00 p.m. to 4:00 p.m.	Immunization Clinic
Friday	8:00 a.m. to 3:00 p.m.	Regional Chest Clinic

Doctor Lawrence, Director, examines all migrants seen in the general maternity clinic held at the health department. Antepartum, postpartum, new-borns, and pap smears are all done in the health department and an IUD clinic is being planned. Tuberculosis and intestinal parasites are treated here also.

An additional clinic at Jones Walker was added one Wednesday night a month, staffed by a dermatologist. This is a general clinic but because of the large number of skin conditions, these patients were channeled to this clinic and received the benefit of a specialist's diagnosis and follow-up.



A fifty-two year old Mexican male is being treated in clinic for an indolent ulcer on leg and diabetes. His blood sugar was 426. He has no family and is unable to work, but is living with friends. Surplus food and clothing were obtained from County Welfare. Medication and dressings were furnished in the clinic. The nutritionist visited him to further emphasize the importance of diet and food preparation. His diet has been closely supervised by the PHN and he is seen often in clinic by the physician. After six months of treatment, the ulcer on his leg is much improved, blood sugar is 183 and our patient expects to return to work in the near future.

Health department staff arranged for boarding care for one hospitalized migrant with a broken leg who would have had to be hospitalized for several months because he was from an all male crew and there was no one to care for him. County Welfare paid for his room and board and a public health nurse gave the necessary nursing care and supervision of his rehabilitation.

TOTAL NUMBER OF CLINIC SESSIONS FROM

May 1, 1966 through April 30, 1967

	No. Doctors' Clinics	No. Doctors' Hours	No. Nurses' Clinics	No. Nurses' Hours
May, 1966	6	18	22	88
June, 1966	3	9	19	76
July, 1966	3	9	19	76
August, 1966	5	15	21	84
September, 1966	6	18	22	88
October, 1966	5	15	23	92
November, 1966	6	18	19	76
December, 1966	3	9	28	112
January, 1967	11	33	26	104
February, 1967	11	33	26	104
March, 1967	11	33	25	100
April, 1967	9	27	26	104
TOTAL	79	237	276	1010

PATIENTS' FIRST VISIT TO CLINIC AND RETURN VISIT

May 1, 1966 through April 30, 1967

MALE	AGE	FIRST VISIT	RETURN VISIT
Puerto Rican	0 - 5	49	107
Mexican	0 - 5	34	74
Negro	0 - 5	18	19
Anglo	0 - 5	1	3
Puerto Rican	5 - 15	42	53
Mexican	5 - 15	15	19
Negro	5 - 15	11	14
Anglo	5 - 15	2	1
Puerto Rican	15 - 45	18	81
Mexican	15 - 45	21	16
Negro	15 - 45	6	14
Anglo	15 - 45	2	1
Puerto Rican	45 +	19	38
Mexican	45 +	5	29
Negro	45 +	6	4

FEMALE	AGE	FIRST VISIT	RETURN VISIT
Puerto Rican	0 - 5	37	75
Mexican	0 - 5	52	47
Negro	0 - 5	17	23
Anglo	0 - 5	3	12
Puerto Rican	5 - 15	23	48
Mexican	5 - 15	25	49
Negro	5 - 15	13	10
Anglo	5 - 15	0	0
Puerto Rican	15 - 45	48	140
Mexican	15 - 45	53	61
Negro	15 - 45	16	36
Anglo	15 - 45	0	0
Puerto Rican	45 +	4	14
Mexican	45 +	8	13
Negro	45 +	6	11
Anglo	45 +	0	0
TOTAL		554	1012

Total Number of Patients seen By Doctors in Clinics 1566

Total Number of Patients seen by Nurses in Clinics 5162

THE MAJOR DISEASES OR CONDITIONS TREATED BY DOCTORS IN MIGRANT CLINICS

(May 1, 1966 to April 30, 1967)

(ASTHMA)

Puerto Rican	Male	Female
0 - 5	4	3
5 - 15	2	4
15 - 45	1	8
45 +	0	2
TOTAL	7	17

Negro	Male	Female
0 - 5	1	3
5 - 15	0	0
15 - 45	2	8
45 +	2	7
TOTAL	5	18

Mexican		
0 - 5	2	4
5 - 15	1	3
15 - 45	0	2
	0	0
TOTAL	3	9

(DIABETIC)

Puerto Rican		
45 +	0	2
Mexican		
15 - 45	0	1
45 +	9	8
TOTAL	9	9
Negro		
45 +	0	3

(COMMUNICABLE DISEASE)

	Male	Female
Puerto Rican		
0 - 5	7	5
5 - 15	6	7
15 - 45	1	3
TOTAL	14	15
Mexican		
0 - 5	4	3
5 - 15	3	7
15 - 45	1	2
TOTAL	8	12
Negro		
0 - 5	3	4
5 - 15	6	7
15 - 45	0	2
TOTAL	9	13

(EARS - SORE THROAT)

	Male	Female
Puerto Rican		
0 - 5	8	11
5 - 15	7	14
15 - 45	9	10
45 +	2	3
TOTAL	26	38
Mexican		
0 - 5	11	14
5 - 15	7	9
15 - 45	2	8
45 +	2	5
TOTAL	22	36
Negro		
0 - 5	5	0
5 - 15	3	5
15 - 45	3	3
45 +	0	21
TOTAL	11	29

(DIARRHEA)

	Male	Female
Puerto Rican		
0 - 5	7	12
5 - 15	2	7
15 - 45	3	5
45 +	1	3
TOTAL	13	27
Mexican		
0 - 5	9	16
5 - 15	3	7
15 - 45	0	5
45 +	1	0
TOTAL	13	37
Negro		
0 - 5	6	8
5 - 15	3	4
15 - 45	0	6
45 +	0	0
TOTAL	9	18
Anglo		
0 - 5	3	3
5 - 15	1	2
15 - 45	2	3
45 +	0	0
TOTAL	6	8

(ULCER)

Puerto Rican		
5 - 15	0	3
15 - 45	6	8
45 +	3	7
TOTAL	9	18
Mexican		
5 - 15	0	3
15 - 45	6	7
45 +	3	7
TOTAL	9	17
Negro		
15 - 45	3	4
45 +	21	1
TOTAL	24	5

(EYES)	Male	Female
Puerto Rican		
0 - 5	19	13
5 - 15	9	8
15 - 45	5	3
45 +	1	0
TOTAL	24	30
Mexican		
0 - 5	11	14
5 - 15	8	9
15 - 45	3	5
45 +	1	0
TOTAL	23	28
Negro		
0 - 5	7	5
5 - 15	3	6
15 - 45	0	3
TOTAL	10	14

(UPPER RESPIRATORY)	Male	Female
Puerto Rican		
0 - 5	45	56
5 - 15	13	19
15 - 45	11	27
45 +	7	11
TOTAL	76	113
Mexican		
0 - 5	19	27
5 - 15	7	28
15 - 45	9	11
45 +	6	9
TOTAL	31	75
Negro		
0 - 5	14	17
5 - 15	6	12
15 - 45	3	11
45 +	7	9
TOTAL	30	49

(CYSTITIS)		
Puerto Rican		
0 - 5	3	5
5 - 15	0	2
15 - 45	4	12
45 +	2	6
TOTAL	9	25
Mexican		
0 - 5	2	6
5 - 15	1	3
15 - 45	0	5
45 +	0	3
TOTAL	3	17
Negro		
0 - 5	0	3
5 - 15	0	0
15 - 45	0	5
TOTAL	0	8

(MUSCLE STRAIN)		
Puerto Rican		
5 - 15	3	9
15 - 45	9	8
45 +	5	7
TOTAL	17	24
Mexican		
5 - 15	3	0
15 - 45	8	11
45 +	5	7
TOTAL	16	18
Negro		
5 - 15	1	0
15 - 45	3	5
45 +	5	7
TOTAL	9	12

(SKIN CONDITIONS)

	Male	Female
Puerto Rican		
0 - 5	17	22
5 - 15	19	15
15 - 45	19	14
45 +	3	7
TOTAL	49	58
Mexican		
0 - 5	9	14
5 - 15	6	17
15 - 45	7	11
45 +	3	4
TOTAL	25	40
Negro		
0 - 5	8	11
5 - 15	7	5
15 - 45	5	7
45 +	0	3
TOTAL	20	26
Anglo		
0 - 5	0	2
5 - 15	0	0
15 - 45	0	2
TOTAL	0	4

(WOUNDS)

	Male	Female
Puerto Rican		
0 - 5	3	5
5 - 15	7	3
15 - 45	3	4
45 +	1	0
TOTAL	14	12
Mexican		
0 - 5	3	2
5 - 15	5	2
15 - 45	3	3
45 +	1	0
TOTAL	12	7
Negro		
5 - 15	3	2
15 - 45	1	0
TOTAL	4	2

The types of disease treated by doctors in clinics are varied. Upper respiratory infections, skin conditions, and diarrhea account for over 50% of visits. When necessary, patients are referred by a clinic doctor to specialists, dentists, radiologists, laboratories, and pharmacists. These referrals are made possible by local doctors participating at a set fee, which is $4.00 for the first office visit and $3.00 for each return visit for the same ailment. Prescriptions and x-rays are charged at State Welfare rates.

REFERRALS MADE BY CLINIC DOCTORS

Referred To:	No. Referred:
Specialists	48
Children's Clinic	35
Dentist	35
Ear, Nose and Throat Clinic	29
Radiologists	14
Laboratory Work	6
Prescriptions	137
TOTAL	304

Most referrals made to other services were completed this year, with the migrants acceptance of responsibility greatly improved. A few forgot and a few got lost, but the majority of appointments were kept.

Tuberculosis screening done in Lee County - May, 1966, through April, 1967 - resulted in 45 patients being admitted to State Tuberculosis hospitals. Of these, the majority were from low-income seasonal workers.

Three-thousand, seventy-six (3,076) x-rays were taken in the February, 1967, mass x-ray survey. Three-hundred, ninety-five (395) of these were taken in migrant camps. The units were scheduled each evening in locations convenient for laborers, i.e., labor bus stops, bars, boarding houses, and stores. These locations were in areas with high concentrations of the Negro population. Eight cases were found and admitted to the tuberculosis hospital. An effort was made to x-ray and skin test all cases admitted to hospitals. Aerosol sputum specimens were collected in the health department when the patient's symptoms warranted this.

HEALTH EDUCATION

Many and varied methods of education were used by the nurses, doctors, and sanitarians in their contacts with migrants. Most effective and rewarding is the individual interview with conversation on their (migrant) level of understanding and demonstration with their own equipment and in the facilities available to them. The Spanish-speaking nurse (funded by Maternal and Child Health Service) has been invaluable in helping the non-English speaking groups adjust to the community. Without this nurse, the teaching would have to be done through a poorly educated interpreter.

(1) "Flip Charts" were used in teaching child spacing to individuals and groups. Instructions were given to 528 women in the past year concerning methods and types of contraceptives used in Family

Planning.

(2) Films were shown on the preparation of foods, and home improvements, (environmental conditions) to groups in camps.

(3) Pamphlets, printed both in Spanish and English, on various subjects concerning health were distributed to the migrants.

(4) Posters and pictures were placed in all clinics. These were of various health subjects and pictorially stressed good health habits. Camp owners were visited and camp conditions were discussed and suggestions given for improvement.

(5) Talks were given by personnel to community groups. The use of newspapers, television, and radio all helped in educating the migrant and the community as to services being offered and problems encountered.

Every opportunity is used to help the community accept the migrant and to realize its dependence upon him for the community's economic welfare. Planting and harvesting is done largely by the migrant and the importance of their presence in the community is emphasized as often as the occasion permits. When the community leaders realize and appreciate their dependence on the migrant worker, they more readily accept their responsibility to accept him as a member of the population.

When a migrant health educator is employed by the state, his services will be utilized by the project staff. Individual instruction and demonstration by the health department nutritionist is received by each prenatal patient and by others concerning nutritional problems.

There were fewer illnesses and less work time lost than last year by the migrants. This was due in part to mild weather, but much credit should go to the care and the teaching given to the migrants by the project staff.

PROBLEMS

A problem which hindered the effectiveness of service and the educational efforts in clinics and camps in Lee County this year was the lack of available facilities for medical services in the Bonita Springs and Alva camps. A night clinic was started in a doctor's office in Bonita Springs, but was discontinued after three weeks. The migrant, after working from sun-up to sun-down, will attend a clinic "set up" in a migrant camp, but after a long day's labor, he is not willing to bathe, dress, find transportation and travel many miles for medical care. The migrant is less reluctant to trust outsiders in his own familiar environment.

Since no facilities were available in the Alva area, plans are being made to move the trailer to the Charleston Park camp on land donated by a camp owner. If a doctor can be found to work in this isolated area (20 miles from Fort Myers) a clinic will be scheduled at night. The trailer will be used by the project nurse, replacing the present clinic held in an open carport. Though nursing services were given this year to the people in this camp, they were rendered without adequate privacy, space, or electricity and with no bathroom or telephone. Group education and demonstrations could not be given in this clinic but this was done on an individual home-visit basis. Here again, the mother who needs the most help is out in the field working and could only be reached through group meetings at night. This has not been possible with our present staff.

Another problem which has not been solved is the need for a child day care center. This brief narrative will illustrate this need:

> Magalia, age 2, lives with her mother, father, and eight brothers and sisters in a four-room house which has just recently had an inside bathroom added. Last year she drank kerosene from a coke bottle. She was treated at the emergency room and released. Three months later, Magalia was burned with hot coffee and seen for several weeks by the doctor in the night clinic. In February, her mother left the washing machine running, unattended. Magalia's arm was caught in the wringer and terribly mangled. She was then admitted to the hospital for five weeks. For this lengthy stay, the total hospital bill was $511.00 and was paid by Lee County Welfare.
>
> Jose, a brother of Magalia, is five years old. When he was being examined for the "Head Start Program," a heart murmer was discovered and a referral was made to Florida Crippled Children's Commission. This condition proved not serious but he is still under observation by a clinic physician.
>
> Another brother, Rafale (age nine) ran across the road and was hit by a car. His leg was broken in two places and he was admitted to the hospital. A body cast was used to keep this young man down, but after being home three weeks, he was found in the kitchen by the nurse with the lower part of his cast broken. Therefore, he was hospitalized again. On another home visit he was found left alone, in charge of his four-month old baby sister.
>
> This is a poor home. The older children are kept from school to act as baby sitters while the mother works. These children range from 13 years to four months.

Rafale, nine years old and in a cast, babysitting with his four month old baby sister.

A migrant Family Planning clinic would certainly help solve some of the problems of "pill" failure and "drop outs." If this clinic were scheduled at hours that working mothers could attend and not lose income by their attendance, we could do more pap smears and could give more complete instruction. Films on child spacing could be shown. With time, education and understanding on the migrant's part, the importance of child spacing and the most effective methods could all be discussed and demonstrated and the problem of unplanned pregnancy could be eliminated.

We improved somewhat our clinic problems this year. We added a new clinic and enlarged two of our operating facilities. Needed and additional equipment was purchased, enabling us to serve our migrants in these areas more efficiently and thoroughly.

An application for funds to cover the cost of inpatient hospital care was prepared and submitted.

During March and April statistics were compiled, hospitals were contacted, and arrangements were made to provide hospital service to the migrants. Both hospitals cooperated and were anxious to participate in this service.

It is anticipated, however, that except for the emergency admissions, some problem may be encountered in the medical certification for admission of the patient because no funds are available for physician's services. It is hoped that in the next year's budget, some funds can be used to pay the physician for his services to the hospitalized migrant. Emergency care to migrants was upgraded by having night clinics regularly scheduled three or four nights each week.

A part-time nutritionist has been added to the health department staff and oriented to work with migrants. She attends migrant clinics and helps maternity patients, diabetics, and others to understand the importance of adequate nutrition.

Vision screening was done by a State Board of Health Vision Screening Consultant on Mexicans ranging in age from 11 to 60 years. Six were found to have some type of vision difficulty. This is a problem which has not been solved. These people are not in the county long enough to receive county welfare. The local Lions clubs purchased glasses for some of the migrants, but they cannot meet the demand as they are already over-burdened by residents considered medically indigent. School children received eye examinations and glasses when necessary through school services financed by Title I funds.

A dental preceptor program has been approved and is expected to be operating in the fall. With this much-needed service another problem will be solved. Though emergency dental treatment has been given migrants by referrals, much corrective therapy is needed.

The migrant has shown more responsibility this year in seeking medical aid, keeping appointments and carrying out instructions. Referrals were sent on 175 migrants and over 100 health records were made as the migrants departed. A few brought health records with them from other areas.

We have had excellent cooperation with city and county officials. The Fellowship of Migrant Mission Board, churches, community groups, camp owners, growers, and the migrant himself. With these improved relations, donations have been made which have greatly decreased the operating cost of clinics. (See Budget) We would like to give credit and thanks to the physicians who served (and still are) in the migrant clinics, local doctors and dentists for treating patients in their offices at "fee-for-service" rates; the Migrant Mission Board, for donating clinic space, electricity and custodial service; the Lee County School Board for clinic space, electricity and telephones. Community groups and churches have furnished money and transportation which enabled the migrant to keep appointments made with other agencies out of the city. These organizations have also donated clothes when needed and layettes.

One group of women from Cape Coral has had several "Baby Showers." Layettes are being made up from the gifts that these women bring, so that each maternity patient will receive new clothes, blankets, soap, powder, diapers, etc. for their new baby.

Examples of typical migrant medical cases:

(1) A 36 year old Negro migrant encountered difficulty after being hospitalized at Lantana Tuberculosis Hospital. Prior to his hospitalization, he resided at a migrant rooming house for men. When the time approached for his discharge from the hospital, the problem arose of where this patient would live and where would the comey come from to feed him until he returned to work.

After combing the area for weeks, finally a room was found. The patient began working in the fields the day after discharge to get money for food, but the work was too strenuous and his breath became short, so he couldn't make enough money for his room and board. The patient and public health nurse asked County Welfare for assistance and obtained a seven dollar grocery order and were informed that this was all County Welfare could do. Finally, after several days of perplexity, the idea was "hit upon" to get the patient enrolled in the government program - "Adult Migrant Education." Now the patient is in school and receives $30.00 per week.

(2) Another patient discharged from the Tuberculosis Hospital was unable to return to work for a month. A room was found by the public health nurse and County Welfare paid his room and board, but this landlord will not accept any more patients unless paid in advance. County Welfare cannot do this.

(3) A Negro family from Immokalee migrated to Alabama and found work. While being transported to the field the bus was involved in an accident and burned. The father of this family was killed, the mother's vertebra was crushed, and she is totally paraplegic. The 13 year old son suffered fractures of an arm and leg. He spent a month in the hospital recovering and is now able to attend school.

The mother and son came to Lee County to make their home with a sister. A physician treated the mother in the hospital and gave the sister instructions for care. The nurse made regular visits to render care and give instructions. A local agency loaned a hospital bed and a wheel chair. Medicine was purchased with project funds. This patient could not read or write but did not seem retarded so a Vista worker was encouraged to teach her to read.

After four months, this patient moved back to Immokalee and is living with her mother.

SANITATION SERVICES

One sanitarian devotes full-time to migrant services and is assisted, when necessary, by the other sanitarians and the Director of Sanitation of the Lee County Health Department, also by migrant aides from the local unit of The Community Action Fund, staff and aides of Southwest Self-Help Housing Incorporated, and the Vista program.

The accompanying map shows the location of labor camps, clinics, housing areas largely occupied by migrants and scattered migrant housing. Camps are evaluated under the Sanitary Codes of Florida, Chapter 170C-32. Housing in the city of Fort Myers is evaluated under a minimum requirement of the City Council passed in 1966 and in the County of Lee by a similar requirement passed as a resolution in 1966 by the County Commissioners.

The following list covers the stable numbers of migrants in Lee County:

0	Carlos Rivera Camp	Estero	20
X	Pine Grove Camp	Bonita Springs	50
	Travis Camp	Bonita Springs	40
OX	Thomas Farm Camp	San Carlos	60
	Creel Camp	Estero	50
OX	A & W Farms Camp	Iona	50
0	Geraci Camp	Iona	30
	Johnson Camp	Teter Road	350
X	Martha's Camp	Charleston Park	35
	Spearman Camp	Charleston Park	50
	Harlem Heights Housing Area	Charleston Park	800
	Charleston Park		150
X	Harlem Lake Housing Area	Fort Myers	600
	Dunbar Area	Fort Myers	3900
	Dunbar Area County	Fort Myers	1900

An additional 3,500 migrants were in the county at the peak of the season.

LEGEND: X - Camps Permitted in 1966 - 1967
0 - Camps Predominately Single Male

The ten camps were visited approximately 300 times. The four permitted camps were in generally good condition at the beginning of the report period but it requires constant contact to keep these camps in this condition. Of the six camps that were not permitted, two were in poor condition, three in fair condition, and Johnson's Teeter Road Camp was in gneerally good condition - except for lack of bathing facilities. This camp now has twelve shower rooms well placed in two buildings. The Rivera Camp, which was poor, now has a new three-room barrack building, a reconditioned barrack building and a good, complete washroom. The Geraci Camp, which is used only part of the season, still needs considerable reworking. The Spearman's Camp is steadily improving and by next season should be in good condition - new buildings are replacing the old and a new washroom will be completed this coming summer. Travis and Creel Camps are located in areas zoned against labor camps, but are in fair condition and have been under surveillance by the migrant sanitarian.

The principle camp defects were:

(1) Poorly kept premises,
(2) Garbage cans uncovered,
(3) Buildings in poor repair,
(4) Roads in poor condition,
(5) Washrooms poorly maintained,
(6) Overcrowding of people in buildings, and
(7) Not frequent enough garbage and trash pickups.

All of these defects were corrected, except for numbers 3, 4 and 6, which were in need of constant checkup to keep camps properly maintained. These corrections were accomplished through the cooperation of camp owners and crew chiefs and by the migrants themselves - understanding better the need for good sanitation.

The reasons for lack of full, continued corrections of defects were:

(1) The owners require time, as our camps are low-rental income, and they feel that it would not be economically feasible to make all corrections at once.
(2) The migrants are improving in their attitude, but they still need continued education in regard to their part in better housing and sanitation. It is felt that they are gradually realizing that they have a responsibility toward maintaining their own premises in a more sanitary manner.

The largest number of migrants are housed in the Dunbar area of the City of Fort Myers and in the adjoining county area. The improvement of housing and premises in this area continues with the premises now generally good and with work on housing progressing. The housing areas of Harlem Heights, Charleston Park, and Harlem Lake have been visited 125 times with 525 units checked.

The Dunbar area is visited two or three times every week, with over 1,000 housing units checked during the year. These visits are a continuing effort in education, checkup on premises and housing improvement. The landlord of one very poor housing complex has undertaken a program of adding bathrooms and has cleaned up all of the premises. The tenants seem to be cooperating in maintaining the area. In this section Community Action Fund aides and the Yellow Fever Mosquito Control Program had a "clean-up" day and, with the cooperation of the County Commissioners, who supplied trucks, were instrumental in having many loads of cans and debris hauled away.

The principal landlord at Harlem Heights is adding 16 bathrooms to his houses and will continue until all are equipped. He has "shelled" most of the roads so that they are usable in all weather. He also supplies paint and building materials for those who want to improve their own homes. Many have taken advantage of this, some painting both inside and out. The Home Demonstration Agent of the State Agricultural Department has cooperated by having some classes in sewing and home decoration here, and at Charleston Park. The Community Action Fund has had a yard of the month award with prizes of money and bushes and trees donated by a local nursery man.

South West Self-Help Housing, Incorporated is building migrant housing in this area and their aides are helping promote better sanitation and improved maintenance of premises. At Harlem Lake, a Community Action Fund aide has been working well with the landlords agent. She has furnished 12 gallons of paint to tenants who want to improve their homes. This cooperation was brought about, after considerable trouble between these two, by the sanitarian acting as mediator of their differences.

At Charleston Park, a child care center is underway. This is under the auspices of the Lee County Child Care Advisory Board. The project sanitarian is a board member and chairman of the facilities committee. Two groups of interested citizens (one from Lehigh Acres and one from Alva) put in water, a washroom, glass in the windows, and screens. Community Action Fund had lights installed. This building is also being used as a community center. Two Vista girls, who live in the community, other residents of Charleston Park, and other volunteers are manning the center. The community is reacting very favorably to this. A noticable improvement throughout the area is evident.

Very little work has been done on field locations because the migrant's living conditions have taken all of the sanitarian's available time. Water is furnished to the field workers by portable water coolers. Cold bottled drinks are furnished with the noon meal. Water is generally available at the field for hand washing. There seems to be no practical method for toilet facilities. Some fields have privies, but because of their location and the size of the fields, they serve no practical purpose.

Group counseling has been tried on two or three occasions, but results are much better when one talks to migrants on an individual basis. This is being done continually.

The Lee County Health Department nurses, as well as the nurses under the migrant program, in their daily contact, cooperate well with sanitation aims. Growers and landlords are becoming much more cooperative as available evidence demonstrates that migrants respond to better conditions. The large growers and grower organizations are now (as expressed at the 1966 Farm Labor Conference) of the mind that to attract good labor, better housing and sanitation must be furnished.

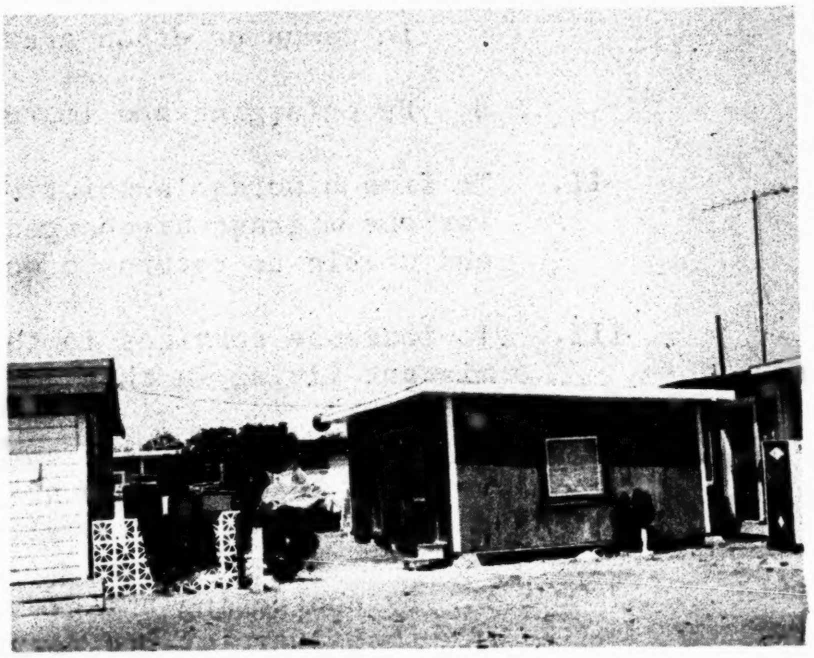
Crew leaders are becoming much more responsive to the efforts of the sanitarian and for the most part are following his suggestions. Two Community Action Fund aides are working closely with our program and are making possible a very close contact with the migrants in the housing areas. Vista volunteers South West Self-Help Housing, Incorporated aides, Mission workers, the Home Demonstration Agent of the State Agriculture Department, City and County officials, and their building departments are all cooperating with our program.

The migrant aides of the above mentioned organizations are being continually contacted and methods of improving housing and sanitation are discussed with them.

It is evident that as the migrant better understands that he has a responsibility toward maintaining his housing and keeping it in a sanitary condition, his living conditions will improve. This performance by the migrant also has the effect of changing the camp owners or landlords attitude towards him. This change in attitude on the part of the migrant has already had a marked effect on the landlord as evidenced by his willingness to make improvements.

The changes in attitude of the migrant and the landlord are also relfected in an improved community relationship. This is particularly true in regard to attitudes of the city and county governing bodies. The continuation of this program will be of advantage to Lee County as far as the future improvement of housing and sanitation is concerned.

Harlem Heights Housing:
New bathrooms being added



Spearman Camp: New building
replacing old one in rear.

ADDITIONAL COMMENTS

Project objectives applicable to Lee County were substantially achieved.

The clinics have been expanded but we still hope to add medical clinics in Charleston Park and Estero. As the mobile clinic did not become a reality and we have enlarged the existing clinics, we will abandon this idea for the present time.

The County Commissioners have finally approved a dental preceptor program and we hope to have this in operation before the next season.

A nutritionist is shared with Collier County and her services will be expanded to reach more groups and individual migrant homes. Her aim will be to demonstrate how adequate nutrition can be achieved with the facilities and the foods available to the migrant.

The short-term hospitalization plan is ready for operation.

The transportation problem has been partially solved by increasing the number of clinics.

Diabetes screening can be increased in clinics because of additional space available.

OBJECTIVES

(FOR THE COMING YEAR - 1968)

I. To continue to improve the health and living conditions of the migrants.

    A. By continuing to bring health services to the people, whether in camps or urban areas.

    B. By enlarging and improving the clinics already in operation.

II. To find a workable solution to the housing and boarding problem for the migrant discharged from the hospital, with no place to go and unable to return to work.

III. To increase services in the urban Negro area and seek out the migrant living in this community.

    A. By contacting the Farmers Market for their registry of crew leaders and contacting these crew chiefs to inform them of services available.

    B. By contacting the growers using these crews and making them aware of the services.

    C. By public health nursing home visits.

IV. Expand Family Planning Services

  A. The public health nurse in her home visits will help the patient to understand and accept "the pill."

  B. To urge those patients who cannot successfully take "the pill" to utilize an I.U.D.

V. To increase Diabetic screening activities

  A. By doing diabetic screening in a booth at the State Fair in February.

  B. By increasing diabetic screening in clinics.

VI. To increase environmental sanitation services

  A. Accident Prevention

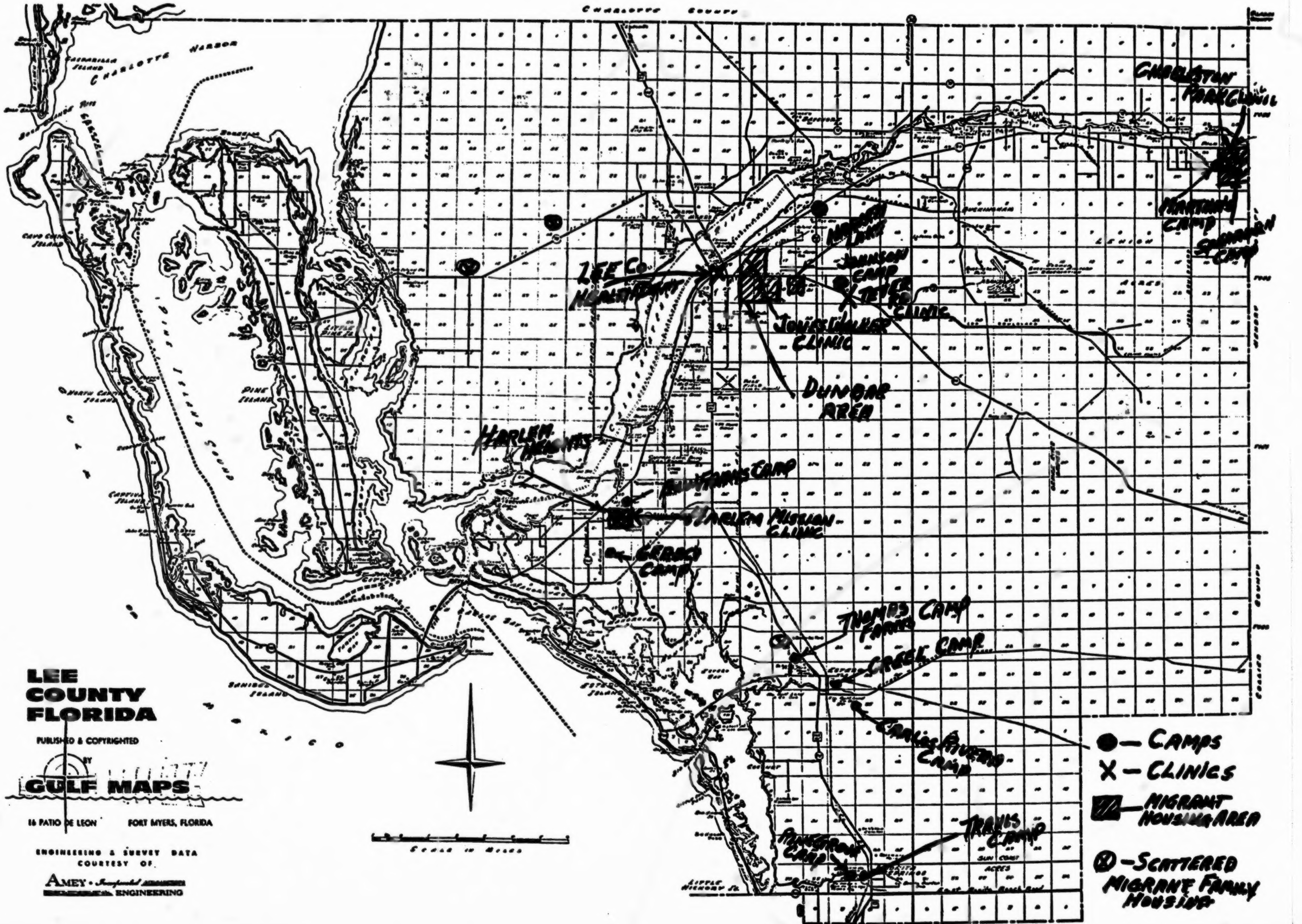
    1. Home Visit - The public health nurse and sanitarian will increase the stress on accident hazards in all visits, as broken glass in the yard; insecticides in pop bottles; broken or weak steps; etc.

    2. Utilize the State Board of Health Accident Prevention Consultant as to the most effective means of presenting educational materials on accident prevention.

  B. Field Sanitation

    1. To contact the growers and work out a solution for their particular problems.

    2. To strive for some practical solution to the lack of toilet facilities for farm workers in the field.

LEE COUNTY FLORIDA
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CAPTIVA ISLAND
ESTERO ISLAND
LITTLE HICKORY IS.
SUN COAST ACRES
CHARLESTON PARK CLINIC
CAMP
LEE CO. HEALTH DEPT
JOHNSON CAMP
CLINIC
JONES WALKER CLINIC
DUNBAR AREA
HARLEM HEIGHTS
FARMS CAMP
HARLEM MISSION CLINIC
CAMP
THOMAS CAMP FARMS
CREEK CAMP
CARLOS RIVERA CAMP
CAMP
TRAVIS CAMP
● — CAMPS
X — CLINICS
▨ — MIGRANT HOUSING AREA
Ⓧ — SCATTERED MIGRANT FAMILY HOUSING

MANATEE COUNTY HEALTH DEPARTMENT

George M. Dame, M. D., Director

Area of County: 701 square miles

Resident Population: 81,000

Number of Migrants: 5,000

Migrant Project Staff: 1 Public Health Nurse
1 Senior Sanitarian

MANATEE COUNTY HEALTH DEPARTMENT MIGRANT PROJECT

This project has been operational for twenty-six months since May 1, 1965. The project is staffed by one full-time public health nurse and one full-time sanitarian. The non-project personnel contribute an average of three per cent of their time to the project with a range of from 0.05 per cent to ten per cent. Prior to the inception of the project, a migrant program has been carried out for many years. There have been migratory agricultural harvest workers in Manatee County since the late nineteen twenties when the agricultural pattern in this area changed. Before this change, in the early depression era, there were many small truck farms with sharecroppers. The small farms disappeared during the depression and were gradually replaced by larger farms principally producing tomatoes. The sharecroppers became migratory at about this time with a majority making this county their home base. The influx of Spanish-speaking migratory harvest workers was a post World War II development but, as recently as 1956, there were very few of them in the county, as noted in a report from the Health Officer to the State Board of Health. Since 1956 the number of Spanish-speaking migrants has increased to about 50 per cent of the total force of some 5,000 peak season workers. Our records indicate that the first migrant labor camp was constructed in Palmetto in 1948 to house Spanish-speaking migrants. The Puerto Rican and Texas-Mexican migrants began to arrive at about the same time. There were a few Brisith West Indians here during the war and this offshore labor supply was used intermittently until 1963. During the past five years, progressively more and more of the Spanish-speaking migrants have begun to drop out of the migrant stream, find other employment, and take up permanent residence. The Manatee County Health Department held a large meeting with principle growers to discuss health department requirements for camps and the first licenses were issued in 1957. There has never been sufficient housing in the camps to accommodate more than ten per cent of the seasonal harvest worker force and the great majority have lived in whatever generally substandard housing they could find. Active programs by the Manatee County Building Department and Health Department have, during the past five years, eliminated much of the dilapidated houses without providing anything else - resulting in a severe migrant housing shortage. There have been a total of 17 camps licensed since 1956, but only seven are now licensed. The population of Manatee County virtually doubled between the 1950 and 1960 Federal census, increasing from roughly 35,000 to 70,000 people. The majority of this increase actually occurred between 1955 and 1960 and was due almost entirely to immigration of elderly retirees. This population explosion produced a great boom in construction and farm laborers deserted the farms for more lucrative jobs in construction.

About 1956, the Manatee County growers discovered that tomatoes could be grown just as well in irrigated cleared flatwoods land as in the hammock land which previously had been used almost exclusively. This finding led to a great increase in tomato acreage.

It was at this time, about 1956, that it suddenly became necessary to bring in large numbers of Spanish-speaking agricultural workers. In the early part of this influx, wages were far poorer than nowadays and many of the migrants actually lived in packing cases, abandoned automobiles, and various crudely improvised shelters. Although the health department did strive to eliminate these deplorable conditions through educational programs and condemnation, there is no doubt that the final, complete disappearance of this problem was brought about by higher wages and efforts on the part of the growers. The Spanish-speaking migrants have had sociological problems fitting into the community. Manatee County, prior to the population explosion which began about 1955, was a typical southern community with the usual pattern of segregation of White and Negro population. The new influx of people have settled in subdivisions and trailer parks which are exclusively White. Until the segregation laws were passed, there were schools reserved for Negroes and others reserved for Whites. The Negro community held to itself and largely patronized businesses operated by Negroes insofar as possible. The Spanish-speaking migrants have always more or less lived in or near the Negro community but have attended both White and Negro schools and patronized business catering to either race. In 1965, for the first time, Spanish-speaking migrants began to infiltrate heretofore exclusively White communities such as Samoset and Oneco and there was a rather violent reaction by these communities against them. Many County Commission Board meetings were stormed by irate citizens who demanded that the Spanish-speaking migrants be removed from their communities by whatever means available. The Manatee County Health Department was approached many times to evict migrants from their rented homes because of faulty sanitary facilities or whatever reasons it could find. Rather than striving for eviction, however, the health department strove to upgrade living standards and generally was successful. After the migrants departed when the season ended, these communities destroyed certain accessible houses and made other arrangements which precluded the return of Spanish American migrants, whom most of the lower socioeconomic bracket Whites of Samoset and Oneco consider Negroes. The Spanish American migrants in Manatee County have, therefore, been relatively confined to the Negro residential communities. The Negroes also view the Spanish American migrant with dubious feelings. Even though they are accepted in their bars and restaurants, schools, businesses, and residential communities, the Spanish American is viewed by the Negro as a different racial entity.

MIGRANT PROJECT

ENVIRONMENTAL HEALTH PROGRESS REPORT

The population served by this project is located in the southwestern portion of Florida. Bounded by the Gulf of Mexico on the west, Sarasota County on the south, DeSoto County and Hardee Counties on the east, and Hillsborough County on the north, the population of Manatee County is estimated at 80,000 persons at the present time. Manatee County has an area of 701 square miles or 448,640 acres, consisting mainly of coastal plains. The county is mostly level with gentle to rolling central and northwestern area. The northeast tip of the county has an elevation of 150 feet with an elevation to sea level along the Gulf coast. Within this county an estimated 3,200 migrant agricultural workers, excluding their dependents, reside during the "season" which begins in earnest in January and ends about June 15.

Some of the large growers plant fall crops of tomatoes from time to time when the weather conditions appear to be favorable. Some of the smaller groups regularly plant a smaller crop. When a fall crop of tomatoes comes into season without undue hardships, a much larger profit is realized than from the same amount of tomatoes which would be grown in the regular spring season. The fall season for this crop is from around October 20 to December 15. Most of the laborers used in this operation are recruited from local sources. Sometimes seasonal agricultural workers having returned from the East Coast

Migrant Stream, join this work and at the same time bring their school-aged children back to a local school. The Farm Labor Office of the State Employment Service estimates this immigrant population to be composed of the following:

Mexicans (Texas-Mexicans, generally)	40%
Puerto Ricans	10%
Southern Negroes	50%

The number of Anglos and Caucasian migrant agricultural workers in this county is so small as to be negligible for purposes of this report.

An estimate has been made at only 15 to 20 workers needed for 1,000 acres of citrus; 500 workers to 1,000 acres of gladiolas; and 1,500 workers to 1,000 acres of tomatoes. It is, therefore, self evident that by far the largest majority of seasonal agricultural workers are primarily used in the tomato crop operation for Manatee County. Other truck crops such as strawberries, beans, cucumbers, eggplants, et cetera, count for employment of some seasonal agricultural workers outside of, and in some cases coincidental with, the regular "season". A number of seasonal agricultural workers are employed during the late summer and early fall by two large grass (sod) farms.

Most of the migrants arrive in the area around April 1 through May 15. The exact date depends upon the work available here, crop longevity in the last area, as well as previous commitments to growers either in the southern or northern portion of the Atlantic Coast Migrant Stream.

Most of the migrants begin to leave this area around June 6 through 10, depending upon work availability here (or previous commitments) and are gone by June 20. Most of the seasonal workers in this area come from Belle Glade, Homestead, Immokalee, and other southern portions of the stream. From personal interviews, it appears that a very large majority of the Negro migrants come from the Georgia, Alabama, and the Mississippi area with relatively few Floridians. The Mexicans are predominantly from Texas with a few from Oklahoma. The majority of the Puerto Ricans seem to migrate annually from Puerto Rico and then return there until the start of the new season. Some Puerto Ricans come into the stream from large northern cities.

The migrants, upon leaving this area, seem to generally follow the Atlantic Coast Migrant Stream, with some deviation to mideastern states as governed by labor commitments. On the other hand, some of the Mexican crews go back to Texas, some to Louisiana, Oklahoma, Ohio, etc. We have no exact knowledge as to towns or areas where the workers are going; due in part to the ignorance of the migrant as to where he will go next and to the reluctance of the crew leader to tie his work down, even verbally.

In the summer of 1965 a Migrant Survey was made to help determine the approximate number of migrants who actually maintain year round homes in Manatee County. The survey used the house-to-house method interview type and was conducted mainly in housing fringe areas which were known to have migrant residents and in outlying areas where the housing was predominantly near the sub-standard level. It is a sad commentary on the life of the migrant that when one searches for migrant housing, the tendency is to invariably go towards a sub-standard group of houses in which to begin the search. The migrant survey which was conducted in the summer months of 1965 has not been carried to its completion, but the material and figures which were procured from this migrant survey have been used to aid the migrant sanitarian and migrant health nurse to better understand that there are groups of people living in this county on a year-round basis who are migrant-oriented and whose entire family makeup is contingent upon the mores and living habits of an on-the-season type of existence. A total of approximately 175 persons were found during the subject survey who were members of migrant families. This is a relatively small percentage of a total of from 3,500 to 5,000 migrants which are in this area at the peak of the harvest season, but it is anticipated that if a house-to-house survey were made in the so-called tenement areas of the local towns, we would find many more of these individuals who are migrant-oriented. Most of the migrants who are tied to or are affiliated with homes in Manatee County will leave about the same time as the regular stream of migrants on their up-the-stream trail, as mentioned in last year's report (1965-66). At that time the survey revealed that 44 per cent of the migrants were Mexicans, 44 per cent were Negroes, and 12 per cent were Puerto Ricans. Personal observation this past season leads us to believe that the percentage of Negroes was higher this season and the Mexicans slightly less than usual with the Puerto Ricans maintaining about the same ratio, 12 per cent.

The number and location of migrant labor camps and other concentrations of migrant housing are covered under "Sanitation Services." The 1967 spring tomato crop season was only approximately eight to ten weeks in duration, with the growing season marred by a drought. There were few problems due to the scarcity of labor; in fact this past year there seems to have been more available labor than there was during the year 1966; that is, the spring crop season for the year 1966. The current year (1967) was marked by heavy rains and quite a bit of cold weather during the first of the year (January, 1967) which necessitated some replanting in Manatee County, but not to the extent which had taken place last year. The first picking started this year around May 10 to 15, the harvest was moderately heavy, and a relatively small number of pickings was made in relationship to the six to eight pickings, or in some cases ten, which were experienced in the 1965 season, or two seasons ago. As has been noted above, there seemed to be no serious shortage of migrant laborers for the spring tomato crop this season.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

STAFF:

1 Public Health Nurse II	100%
1 Senior Sanitarian	100%

(The position of Senior Sanitarian has been filled.)

There were no volunteers used in the carrying out of sanitation activities.

Laws, Regulations, or Other Criteria for Evaluating Camps

Camp evaulation procedure has been developed in conformance with Chapter 170C-32 of the Sanitary Code of Florida.

Camp Locations in Manatee County

Table #1

Number of Camps in Area by Types and Location

Table #2

Purpose of Visits

Total Number of Camps visited	8
Total Number of visits to Camps	143
Water Supplies, sampling, etc.	41
Sewage disposal systems	18
Child care centers	101
Investigation of complaints	30
Complaints corrected	16
Conferences	214
Inspection - Food service facilities	6
Public premises	68
Private premises	438
Other	59
Total number of visits	1,142

In the previous report, the third annual progress for 1965 and 1966, it was noted that there were only eight camps, seven of which were permitted by the Florida State Board of Health.

TABLE #2

NUMBER OF CAMPS IN AREA BY TYPES AND POPULATION

Key Number	Name	Purpose	Permitted for
6	Valley Farm	Migrant Labor Camp	100
8	Whisenant	Migrant Labor Camp	135
7	**Foy Labor Camp	Migrant Labor Camp	78
2	Jackson Field	Migrant Labor Camp	36
1	Ellenton-Gillette	Migrant Labor Camp	47
3	Warren Edwards	Migrant Labor Camp	65
5	***Burnett's	Migrant Labor Camp	50
4	*VISTA	Personnel to work with Migrants & Migrant problems	90
	Hatcher	Not permitted, not completed, plans are being made to reactivate this as a labor camp and at that time proper inspection and permitting will be performed	72
	Ward's	This proposed labor camp is now being prepared with due construction taking place towards securing a labor camp permit. It is unpermitted at this time even though extensive repairs	

have been made. Upon its completion it will have approximately 66 migrants.

Total Camp Population -- 779

* Vista Training Camp has been closed for approximately six months. It is not known when, or if, this camp will be reactivated, even though the current permit is valid until June 30, 1967.

** Foy Labor Camp has installed (as an addition) four small semi-detached cottages with a total occupancy figure of 12, thereby increasing their total camp occupancy to 78.

*** This is a new camp which was activated and permitted for the first time this past season.

Chief Methods Used in Obtaining Correction of Defects

The migrant labor camps in Manatee County are permitted in accordance with Chapter 170C-32 of the Florida State Sanitary Code. The Manatee County Building, Electric, and Plumbing Codes must be conformed with as well as the Fire Marshall's recommendation and previously mentioned sanitation regulations, with the fire inspection being made before the permit is issued. This permit is issued by the Florida State Board of Health in Jacksonville.

The problems and defects which arise are discussed both from a personal viewpoint, from an overall viewpoint, and with a friendly direct discussion, in an effort to get the person involved to see the problem. In some cases they suggest a remedy themselves before regulations are resorted to which result in embarrassment and sometimes hard feelings between the various people involved. The chief method used is friendly persuasion, and this concerns itself with personal consultation and discussion. The majority of defects usually are completed or corrected after they have been specifically and continually mentioned to the crew leader or the supervisor so that they may understand what needs correction, and the advantages which would accrue to them upon its correction. At this time we still have no camp large enough to have a camp maintenance foreman. Even the most minor defect correction takes much repetitious action. Rarely does one visit correct more than one defect. The crew leader, if he is available, is the person usually consulted; in his absence, his wife (if she can speak English) is consulted, shown the defect and the reason for fixing and what must be done will be shown to her. In some cases, one has to talk with an 8 to 12 year old child of the crew leader who acts as interpreter. The normal reaction of the crew leader's wife is "talk to my husband, he is the one who makes the decisions". When rapport is established with any member of the crew leader's family, the minor defects are rather quickly repaired and the larger defects take some time, but they do indicate an interest in them until such time as they are repaired. It must be understood that most of the crew leaders do not make the repairs out of their money, but repairs are paid for and must be approved by the owner prior to any major defects being fixed. This is why normally the major defects concerning water supply problems, structural defects, garbage disposal, adequate housing, etc., are discussed with camp owners and when necessary followed up with certified letters delineating the defects. We have had to send very few letters. It is believed that in general the reason for not repairing building defects of a minor nature is due to a feeling of apathy.

This attitude is indicated towards the entire housing problem. The crew leaders are rather difficult to find in camp for a detailed job inspection at any time except after dark. The crew leader will normally, during the day, either be in the field with the workers, or will be in town or gone somewhere trying to line up other work. When the crews come in from the fields at night they are tired and very few problems except their personal ones interest them. On the larger defects which require money to be spent, the owner/operator is reluctant to make an expenditure which he feels may be wasted due to the fact that, in a large number of cases, housing is vandalized by the persons who live there either during the time they live there or immediately before leaving. There seems to be very little feeling of the personal property concept. The sanitarian must work very closely with both the crew leader and the owner in their complete confidence and respect as an individual who knows the sanitation field. After a friendly relationship has been established, even the camp owners come around to the actual spending of cash which is, in some cases, impossible to do until such rapport is established.

It is without doubt, completely frustrating to the owner to keep putting money into camps and to continually have to make repairs for the same group, sometimes weekly over the same season. The entire energy of the migrants, the crew leaders, the owners, and all others concerned during the tomato crop season is to get the crop in and repairs often have to wait until this is accomplished. In the event of freezes, heavy rains, heavy storms, things of this nature are readily noticed very little, or no work is done at the camp when the people are needed in the fields to salvage crops.

Other Types of Housing used by Migrants

It is estimated that approximately 2,500 to 3,000 migrants or 80 to 85 per cent of the total migrants in Manatee County do not live in camps but in private homes, rooming homes, and apartments. Most of this housing is located in the municipalities of Bradenton and Palmetto. However, a number of families live in rural and unincorporated areas. In the last two years there has been a definite tendency of the migrants to prefer town living to the camp living situation, even with the monetary saving which would accrue to the family as the owners often do not charge rent for the camps. They would still prefer to live in a community type situation where they have some recognition as individuals in a community.

Laws, Regulations or other Criteria for Non-camp Housing Evaluation

As many individual or single family residences or duplexes are not subject to the Florida State Sanitary Code as applied to camps, Chapter 32, or to the Hotel and Restaurant Commission regulations, the laws of the state as well as the local legislative acts are used for regulations and for correction of insanitary conditions. Manatee County has Zoning, Building and Housing regulations which are enforced by the respective County Inspection Departments. The Southern Standard Building Code is used as a criteria by the Building Department. Those non-camp housing establishments, such as rooming houses and apartments which fall within the purview of the Hotel and Restaurant Commission are so regulated by them and are licensed by them.

Sanitation Services to Migrant Housing Outside of Camps

It is estimated that Manatee County has about 65 general locations including rural single houses in which seasonal agricultural workers reside. This is both singly and in family groups. Thirty-eight of these locations were visited during the project. They were generally as individual family units of the fringe or "rural" and were a furtherance of the investigational survey which was conducted during the summer of 1965 as previously mentioned. No specific records were compiled at this time as to housing inspection because the prime mission of the survey was to get an overall picture of the migrant families. That is, those families maintaining a residence in the county having one or more members following the stream. The defects were noted which were of a very flagrant nature and were reported to the owner, or landlord after an appropriate interval. It continues to be our opinion that one of the major difficulties in housing lies in general overcrowding of small units. Septic tank failures, overloaded garbage bins, inadequate cooking facilities, negligible safety precautions, and general insanitary conditions were (in practically all cases) caused by the lack of personal sanitary facilities.

It is estimated that at present there are approximately 100 farmers in Manatee County growing 4,500 to 5,000 acres of vegetable crops. This is only an estimate and has been arrived at with due consideration to the fact that some of the farms in the Piney Point area which have been taken over largely by the phosphate industry or in some cases by the Borden Company complex, are no longer operative as farms. Fifty-seven visits were made to 24 separate fields where migrant work was taking place in the picking and handling of vegetable crops during the project. As of this date, no field inspection form has been evolved, but personal notes were taken of the major discrepancies. In the majority of cases noted, drinking water was taken to the field from an approved camp or city water supply. When proven otherwise by checking of water samples taken by the sanitarian and brought into our laboratory and tested for coliform, crew leaders and owners were informed and advised to secure an improved supply and were rechecked to see that this was done. The use of the common drinking cup is not as much in evidence at this time as it was in the fields one and a half to two years ago. Paper drinking cups are being used and now one of the problems, from an esthetic point of view is to have these paper cups picked up and buried or burned. It has been noted that the average migrant seems to have much better idea of the need for individual drinking cups than appears to have been the case in previous years. Handwashing facilities are no problem and at least four to six of the fields have running wells and handwashing facilities are made available in the irrigation ditches. Of course, they are advised to wash their hands at the well itself. At least five owners furnished field toilets this last season, the balance using nearby woods or the fields themselves. At least two brand named, approved, portable toilets, or chemical toilets are now available for rental in this area - with the price averaging approximately $30.00 to $35.00 per month per toilet. These toilets are constructed in an approved sanitary manner and conform with all existing laws and regulations pertaining to their use. Very little garbage per se is brought into the fields inasmuch as most of the migrants have a noonday meal made up of sandwiches and soft drinks or they have powder-type soft drinks in glass jars or plastic jugs. Paper debris is a general nuisance more than a sanitary hazard in this case and is generally confined to a small area and the better crew leaders see that it is picked up and buried or burned. It is believed the use of soft drinks (in their plant sterilized bottles) which are used for field consumption is a plus mark for sanitation. It has been found that soft drinks in sterile bottles are drunk much more than water which is carried to the field in kegs, or cans; the water in the cans or kegs at times possibly comes from undesirable or questionable locations. The regulations concerning field sanitation are nonexistent with the exception that general provisions of the Florida State Sanitary Code may be applied. A significant amount of time spent with the migrants, the crew leaders, and the owners in the area of field sanitation seems to have borne fruit during this last year or two as evidenced by the fact that we have more fields with portable privies or chemical toilets and a higher usage rate per field. It is felt that definite regulatory efforts should be made in the area of field location of chemical toilets.

Examples or Purposes and Methods of Educational Efforts

Educational work was done by the sanitarian with the owners, crew leaders, individual migrants, and other disciplines in this field. A great amount of work was done in conjunction with the Headstart Program and other offices of Economic Opportunity type problem both as to education in camp and community areas and in formal kindergarten or classroom situations. In general, however, the educational work went on to specifics as the direct result of discrepancies noted in camps. This applied to new camps being constructed, old camps being renovated or relocated, enlargements or changes in camp facilities, etc. The situation was thoroughly gone over in advance of the meeting with crew leaders and/or owners at which time the situation was presented. Specific governing regulations to be utilized were noted and then general and specific discussion and conferences as to when and how the problem might best be solved was discussed. In reference to health education, conferences by sanitarians were held on such subjects as shelter, fire protection, camp site, and camp site plumbing, sewage disposal, water supply, sanitary facilities and other general or specific topics.

Specific Problems by Example Involved in Counseling in Sanitation

Sanitary Facilities:

Plans concerning the camps themselves, the sanitary hazards of the camp or that portion of the camp or its environs which were concerned with sanitation, were submitted to the health department for discussion and review and recommendations prior to any work being started. Then health department approval would be obtained prior to the issuance of the county building permit.

Shelter:

General discussion with crew leaders in minor cases, specific instructions to owners and/or crew leaders in case of major damage caused by storm, fires, vandalism, etc.

Fire Protection:

Prior to the permitting of a camp there is an inspection and recommendation by local fire inspectors. Results of such inspection, plus specific recommendations are sent to each camp owner. Then follow-up visits are made to insure compliance.

Water Supply:

Water supplies for camps are checked and bacteriologically sampled at least three times during the normal season. When found beyond the "satisfactory" range in coliform count, the owner is immediately notified and given remedial instructions. Follow up is then made and repeat samples are taken until the conditions have been corrected and a satisfactory water quality is achieved. If the water is found "unsatisfactory" upon the second or third trip, we would recommend that bottled drinking water be used until such time as the coliform count was brought into "satisfactory" level. This high coliform count when it has appeared, has been rectified without delay by the owners and we have not had occasion to have bottled water utilized. At one time the Vista Training Camp used bottled water due to the iron and sulphur content of the normal water which was available until such time as a water filter device or softener was put into their system. When the water bacteriological test is found "satisfactory" the report is sent immediately to the owner.

Sewage Disposal:

Plans for sewage disposal at all new expanded camps are reviewed and approved. A personal check is made during the construction and facilities are approved by the sanitarian or building department for completion before a permit is issued for the camp. The sanitary facilities or sewage disposal facilities at established camps are checked several times during the season for compliance and any discrepancies are immediately called to the attention of the crew leader and the owner.

Plumbing:

All plumbing in migrant labor camps is under the regular inspection service of the County Plumbing Department. Plumbing maintenance is one of the greatest headaches of migrant camps. This is evidenced by the fact that lavoratories and commodes are often found torn completely away from the walls, toilets are found stopped with wadded toilet paper, beer cans, rocks, sticks, and other assorted objects. When this situation is found, the crew leader and owner are both contacted and advised as to the conditions. Immediate steps are taken to have the conditions put back in sanitary condition. An effort is also made to have the owner and crew leader see that all crew members understand the seriousness of the problems and to take steps to deal with such conditions with a view of eliminating them.

Campsite:

One of the greatest problems found in most campsite areas from an esthetic point of view is the continual lack of proper maintenance in the area of the premises. Trash is thrown around, premises are not kept clean, garbage cans are kept open or scattered and the grounds are very rarely, if ever, policed. This may be considered one of the continuing duties of the sanitarian who visits camps - to keep a sharp eye on the policing conditions of the area. It seems to follow that when a camp is neat in appearance and the premises are kept picked up that other sanitary discrepancies fall to a much lower degree than when this is not true. It is still our contention that all camps would be better off, both from a financial and sanitary condition, if a camp maintenance person were employed to take complete charge of the physical aspects of the camp. Even the small camps would do well to have one person who would act as major domo for the camp and see that it is kept in a neat, sanitary condition.

General:

The complaints in areas whose inhabitants are predominantly migrants are referred to the Project sanitarian. These may include complaints that migrants are in a neighborhood, that they are dirty, they are foreign, and the people in that neighborhood will have nothing to do with them, that they bring lice into the schools, steal everything in sight, and like complaints. A complaint investigation is made with the explanation to neighbors regarding housing shortage and request for cooperation. It is heartening to find that in most cases, after a migrant family has lived in a neighborhood for a relatively short length of time, they are at least tolerated, and in some cases accepted with a good show of "live and let live." Frequent meetings and conferences are held in areas where confusing conflicts may arise and do arise, such as the Florida State Hotel and Restaurant Commission, building departments, sub-standard housing inspectors, the interested property owners, the housing director for the Community Action Fund, and other interested civic and official groups having to do with the community which may be impinged upon or may impinge itself upon the migrant situation.

Types of Individuals and Groups with whom working relationships were established and purposes of Relationships:

Florida Hotel and Restaurant Commission:

Joint discussion and coordination with a view to upgrading conditions by educational means and enforcement of prescribed standards in dwelling units that may be under such supervision.

Fire Departments:

Joint pre-licensing fire inspections of camps with recommendations and continuing advice to camp owners. This has brought some very fine results and it is estimated that at this time 90 per cent of our camps do have adequate fire protection with an early compliance of the other 10 per cent foreseen in the immediate future.

Agricultural Experiment Station, Palmetto:

Information and data regarding crops or yield and farmer problems, etc.

Community Action Fund (OEO):

Continuing conferences and coordination to improve working and living conditions of migrants with special emphasis presently being placed upon housing in areas outside camps, also continuous correlation, coordination, and work with the various facets of the OEO, the Community Action Fund itself, and the Vista organization in the field of education where mutual benefits accrued to all concerned.

County Building and Zoning Department:

Coordination and development of rules and criteria for the betterment of migrant sanitation and living conditions as pertains to plumbing, structural details of housing, zoning, and so forth.

Orientation and Inservice Training of Staff

The migrant project sanitarian attended all health conferences dealing with migrant problems on an area wide basis. Also attended migrant orientation meeting of Florida Christian Ministry. Attended many joint migrant oriented meetings on convention level. Attended weekly sanitarian staff meetings in the health department where inter-related problems concerning migrants were discussed with a view to betterment of situation by throwing open questions to the entire staff for a more diversified opinion on specific questions or subjects.

Problems which prevent Proper Maintenance of Facilities

One of the primary problems which seems to arise between migrants and owners is the apparent disregard of the migrant for property rights, especially that property belonging to owner of the camp. This is not only true in the migrant labor camp situation, but also carries over to individual housing facilities. This last statement is based on interviews with various individuals who rent from time to time to migrant families. This wanton destruction of property such as windows, screens, and sanitary facilities on a frequently recurring basis of approximately once every week or two has made the growers feel that anything they do toward seeing that the facilities are made better for the migrants is a wasted effort and wasted money. As it is very unusual for a grower to ascertain which of the migrants has caused damage to the property, all of the migrants are suspect. Some general improvements have been effected by conferences with the growers and crew leaders. This is with the view to proper supervision and with the recommendation that camp supervisors be appointed for each camp. Excess use of water, electricity, other facilities, seem to possess very little meaning to the average migrant and very frequently the lights are left on at all times, water is left running with no thought of conservation. It has been found, however, that in some instances crews which return from year to year to the same grower, or same camp location show more respect for property than those who are on a truly transient basis and occupy a different camp each season. Close personal supervision by the owner is considered one of the musts in order to maintain camp discipline and the sanitary facilities in the best possible order. In at least one of our camps the owner visits the labor camp a minimum of twice a week and has frequent conferences with the camp leaders and their wives as to what is wrong and where the responsibility lies for having this situation repaired. This type of cooperation between crew leaders and owners is to be desired. One of the camps where the owner visits at two to three day intervals had less than $40.00 worth of breakage during the entire season with a peak load of approximately 60 persons. This is considered remarkable.

Problems which prevent Growers from making Improvements

Due to the short duration of the tomato crop season and the acuteness of the labor need for this amount of time (possibly two months, and also due to the fact that the camps are used only about two months a year, farmers and growers are somewhat reluctant to spend large sums of money on the camp operation and repair from a physical standpoint. It is felt that much of the negligence of the growers is due to procrastination. There is a fairly long time lapse between the time when one group of migrants leave and the next group come back; from nine to ten months. The feeling is that "we have plenty of time to rectify these discrepancies without spending money at this time." Then when the crop is imminent small groups of migrants begin to come in, one to three weeks ahead of the general group of migrants and in order to retain their services the grower must find a place for them to live. Therefore, he will put them into the building without checking with the health department (this is a general rule) and with little or no repairs being made of the previous years' discrepancies. This situation may go on for two or three weeks and then the farmers are innundated with a horde of migrants coming in that must be housed, arrangements must be made for the individual migrants to have food, and while the crew leader is primarily responsible for the health and general welfare of the migrants, the owner is certain to become involved. The tendency is to have the migrants come in when they are needed the most. This makes for a helter-skelter, hurrying type of operation which leaves little time for the more necessary aspects of sanitation and well-being of the individual migrant. Most of the large operations are still "one man" affairs as applied to the overall effort. It is believed that this procrastination and the hesitancy to spend cash before it is absolutely necessary on things other than the crop itself or crop related items are the biggest factors which prevent growers from making improvements at an earlier date. An "act of God", so called, which necessitates replanting of the crop, or any other unusual occurrence only accentuates the above problem.

Problems which prevent Migrants from Maintaining facilities

It is believed that the drabness of the average labor camp is one of the primary reasons for the discontent which leads to poorly maintained facilities. Even at inception, most camps do not lend themselves to a comfortable degree of living which would engender any spark of pride in the persons living in them. Privacy is certainly at a premium, fixtures such as coat hangers, storage space, etc. are in general, primitive and offtimes inadequate. It is felt that the majority of the migrants resent the title of "vandals", based on the actions of a relatively small minority of these migrants. Some have pride even though they may be in a low socioeconomic situation. General kitchen facilities for large numbers of families have been found to be unsatisfactory due to several factors, including small food budgets coupled with large family groups. The food is prepared in their quarters and tends to attract insects and make for insanitary conditions. In all fairness, many of the problems which prevent the migrants from maintaining facilities are not of the migrants making, but are due to poor projection of the camp's use at its inception. Invariably a camp will be overcrowded at some time during the season to such a degree that personal sanitation becomes a secondary consideration to space. A building or room may be permitted for a maximum of three individuals and yet too frequently a family of four or five may move in, and other quarters not being available, will be forced to accommodate themselves to the very limited space which is available.

Other Problems

Except where the "camp" situation is in evidence, there appears to be a growing tendency for crew leaders from both this county and other surrounding counties to pick up and deliver workers for only one or two days, then the next week they will move to another area and have another crew. This is one of the facets which makes it extremely difficult for the project staff to maintain contact with the majority of the crew leaders. It is realized that crew leaders are (or appear to be) a group of free lance operators and as such are very difficult to tie down as to location, mode of operation, place of operation, and efficiency of operation.

In cases where we have located individual groups or family groups or small groups, in unused housing (so called "squatters") the problem has been materially remedied with the cooperation of the County Building Department, Sub-standard Building Inspector. He is an invaluable aid in his normal rounds in spotting these sub-standard houses and working in close cooperation with us, has informed us of their existence and has used his influence to either have the major repairs made, or as soon as the migrants have gone upstream, to have the house "posted" so that others may not move in without necessary repairs having been effected.

GENERAL APPRAISAL OF RESULTS OF SANITATION SERVICES REGARDING:

Migrant understanding and acceptance of responsibility for improvements of their own premises in the use of housing and field facilities. The average migrant, as has been noted, is usually adverse to accepting responsibility. It has been noted, however, that where conditions permit such as a camp with adequate facilities, a clean camp, a large enough camp, a surprising number do show the beginnings of a degree of responsibility which has not been shown previously. This is especially true when the individual migrant, or the migrant family has separate facilities. The "singles" or "floaters" seem to be the prime trouble makers and most of these individuals refuse to accept responsibility. Family groups on the other hand, seem to accept more responsibility and in general appeal more to the owner.

Camp and other owners acceptance of responsibility for providing and maintaining facilities in an acceptable manner. Growers, as a group, realize that facilities and adequate housing must be furnished to the migrants in order to insure themselves a labor supply when it is needed. Still, they are reluctant to spend large sums of money and feel that this is, in some cases, an unnecessary burden and a nuisance. Recently through personal conferences and demonstration, the growers are beginning to realize the direct correlation between better facilities, better workers, less damage, more production and consequently more profits to themselves.

Community understanding of the situation, relationships and attitudes. The general attitude in most communities is that the migrants are a necessary nuisance and must be put up with due to the complex makeup of the marketing system. Even some of the civic groups stress what must be done for the migrant and how it shall be done rather than working for a more tolerant general acceptance of the migrant and inviting his thoughts or involvement in any project which they may have in mind. It is felt that in many cases both official groups and the civic groups somewhat defeat their own purposes. It has been noted that when an area becomes familiar to the migrants that are returning to the same area from year to year; the same families seem to acquire friends among the non-migrants. There has been, in the last two years, a much broader general acceptance of the migrants as individual citizens rather than an excluded work group with no social significance. This is partly due to familiarity and also partly due to the publicity which has been given to the migrant problems in the entire migrant situation, in the last year or two.

Grower-Migrant relationship, willingness of migrants to stay throughout the season, etc. In the case of the Puerto Rican families and Mexican families, the same crews generally return year after year to the same camps, or if not, to the same camp, to the same general locality. This is governed primarily by the labor commitments as secured previous to the season. Most of the crews generally remain for the entire season. There seems to have been very little defection from one camp to another during this last season. The season was relatively short but with very few untoward instances due to reshuffling or proselyting of one crew by the crew leader of another crew. As usual, some crew leaders left early due to prior commitments further "up the road."

Disease conditions attributable to poor housing and sanitation. We know of no diseases which occurred that could be attributed to poor housing or living conditions. A strong child immunization program for migrant children has been carried on continually in this county since the inception of the Migrant Health Project.

GENERAL APPRAISAL OF ADEQUACY OF SERVICES

Each of the labor camps in the project area were visited several times during the course of the project. Complete inspections were made with necessary followups, this included inspection of kitchen facilities where present. Deficiencies were discussed with the respective crew leaders and/or the owners. No overall program of "other than camp" housing was in effect. Further future effort should be directed to this phase of the project. Adequate housing both as to the physical number of houses and the space in the houses which may be available is of prime importance in the solution of the problem.

This project has a mobile clinic program which has been in effect for the last four months. Its primary use to date has been as an adjunct to the dental program in examination of the oral hygiene of the migrants, their problems and needed remedial action. That phase of the project by which migrants are allowed to go to a local doctor with the project paying part or all of the medical fees incurred has not been implemented in this county as of this time.

Health education for the growers, crew leaders, and migrants was of an overall, general nature due to the time limitations placed on one sanitarian. He is greatly aided by the public health nurse. Our project does not have a health educator.

OTHER INFORMATION AND SUGGESTIONS

In this paragraph we reiterate our feelings which were stated in the 1965-66 (Third Annual Report) that adequate, good housing was the primary problem facing those who would better the migrant conditions and standards. The major drawback to adequate housing, both camps and other, is the short-term occupancy of the tenants. It is felt that the camp sanitation picture will be much brighter if strong supervision were put in each camp with a concrete standard of sanitation to be strictly adhered to. Every effort should be made to put all camps on a central waste water treatment system and do away with existing individual septic tanks and privies. More studies should be directed toward uses of approved portable toilets for better field sanitation.

PUBLIC HEALTH NURSING SERVICES MIGRANT PROGRAM

SEASON 1966-1967

I. Family Health Service Clinics

Participation in the total migrant health program has been as follows:

As of February, 1967, we no longer operated a maternity clinic from the health department, thus closing this avenue of contact with the migrant family.

Nursing services are still limited to teaching and immunization clinics with a large amount of the nurse's time being spent in field visits to the migrant camps. Many of these migrant families live in individual family housing settlements scattered throughout the local Negro community. Much of this visiting was done as followup to school referrals. A concentrated effort was made on the part of local educational programs aimed at getting the migrant children enrolled in school immediately on their arrival in the county. This has provided the nurse an access to the migrant homes in many instances.

Although Community Action Funds were withdrawn from the Rubonia Day Care Center at the beginning of this reporting period, private funds operated the center successfully through the fall of 1966 and spring season of 1967. This center provided services for a great number of the children of migrant workers. These children were screened for parasites, immunized as needed, and when evidence of gross abnormality existed, were referred either to local physicians or to the Florida Crippled Children's Commission.

II. Type of Facility Used at Each Clinic Location

In January, 1967, a new Mobile Health Clinic was made available for health department use by the County Board of Education. This was secured by funds from the Elementary and Secondary School Act. This has been used to advantage in the two year round day care centers which are multi-service in Palmetto and South Manatee Health Start Center in Bradenton. A large number of migrant children are enrolled in these centers.

From this unit immunization clinics, hearing and vision screening were done. Night clinics were held from the unit in two camps and in the Parrish community where a concentration of migrant families spend the season.

III. Clinic sessions and services:

TYPE OF CLINIC	SESSIONS	HOURS IN CLINIC	PATIENT VISITS
Nursing	7		67 (approximately)
Medical	3	9	75 (approximately)
Dental Survey	3	9	70

IV. Persons referred to other sources for service:

Children - 5 Adults - 15

V. Examples of Purposes and Methods of Educational Efforts:

As in previous years a continued effort in counseling has improved sanitation and personal health habits to a segment of our transient population who usually have little or no interest or concern about such matters. This is due primarily to a combination of apathy and inability to overcome the deplorable housing and sanitation facilities available to the migrant laborer.

Skin diseases such as Florida sores, impetigo, etc, continue to plague the migrant child who plays most often in filth and dirt. The migrant wife and mother continue to be the most concerned with some method of planned parenthood. The nurse is more often approached with a request for "pills" than any service the health department offers.

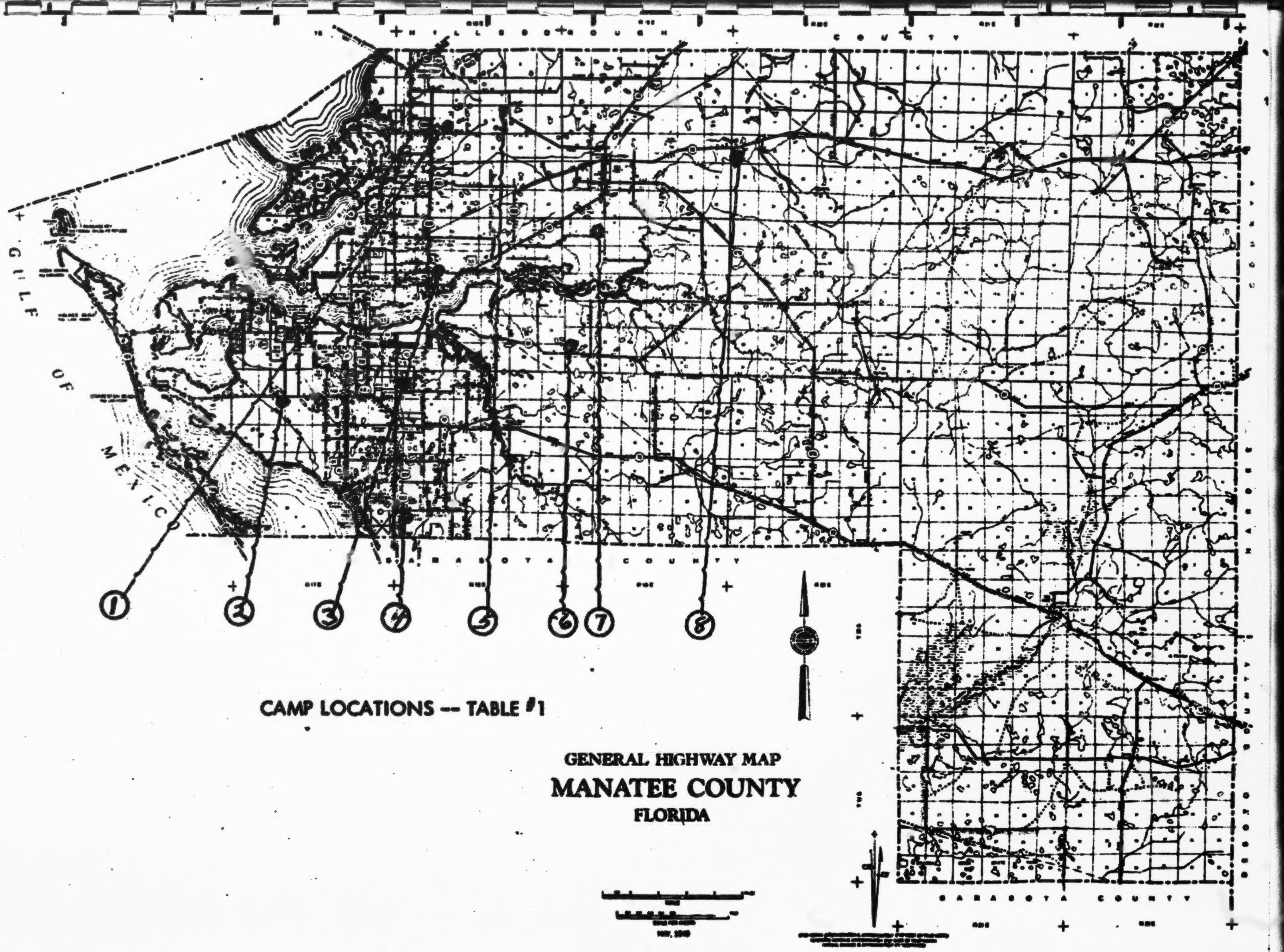
No. of pregnant women contacted - 19
No. admitted to Planned Parenthood - 10

Our night clinics, which were staffed with two nurses and on one occasion with three nurses and the county health officer, were quite successful. Here oral contraceptives were dispensed, blood drawn for serology, and examinations made for numerous and varied complaints from sore throats to dressing of wounds.

In some areas the county is no nearer a solution to providing really adequate medical services to the migrant than during the last reporting period. We continue to see most often the acutely ill individual in an emergency situation; for example, during a routine check of a migrant camp the nurse found a young woman with what appeared to be an acutely abscessed and gangrenous foot. She was transported to the health department, examined by the county health officer who requested her admission to the hospital by the doctor on call in the emergency room. It was determined almost immediately that she was a diabetic. After lengthy hospitalization with conservative treatment - including a "lumbar sympathectomy"-she was discharged to be followed by the health department. She had soon returned to the fields to work although not physically able, and after securing enough pay returned, we hope, to her home in Virginia where her local medical record was forwarded.

In summary, the public health nurse's work in the Migrant Program represents generalized public health nursing services to this often medically and socially deprived group who spend a season of time in our county each year.

Nursing Field Visits		
	Children - 286	Adults - 92
Nursing Office Visits		
	Children - 50 (Approx.)	Adults - 35 (Approx.)
Dental Clinic		
	Children - 13	Adults - 0


HILLSBOROUGH COUNTY
GULF OF MEXICO
SARASOTA COUNTY
HARDEE COUNTY
DESOTO COUNTY
1
2
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4
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8
GENERAL HIGHWAY MAP
MANATEE COUNTY
FLORIDA

CAMP LOCATIONS -- TABLE #1

MARTIN COUNTY HEALTH DEPARTMENT

Neill D. Miller, M. D., Director

Area of County: 568 square miles

Resident Population: 16,900

Number of Migrants: 1,100

Migrant Project Staff:
1 Public Health Nurse (Part-Time)
1 Sanitarian (Part-Time)
1 Clerk-Typist (Part-Time)

ANNUAL PROGRESS REPORT

MARTIN COUNTY

DOMESTIC AGRICULTURAL MIGRANT SITUATION IN PROJECT AREA

Surveys of the migrant population have been conducted by the Sanitation staff from January 1 to June 1 of this year. The purpose being to determine the number of migrant agricultural workers moving into the county. The surveys were made in the Booker Park area of Indiantown, Little Dixie section of Stuart, and the Gomez and Dunbar sections of the Hobe Sound area. By and large, it was noted that the majority of workers resided in the Booker Park area with very limited numbers living in the other areas mentioned. This information has been verified by the County Agricultural Agent's office to be accurate, as well as could be determined from available information. From January 1 to March 1, the migrant population was limited but showed a gradual increase between these dates. This was due to the shortage of work available. Most of the jobs were limited to two or three days per week at best, and some were even less. The available jobs were in crop or grove cultivation since harvesting was limited to very few varieties of row crops. It was noted in the Booker Park area that a steady population increase occurred between March 1 to May 1, when a peak was reached. This peak of population coincided with the peak period of harvesting and continued until June 1 for about a five-week period. At this time it was estimated that approximately one-thousand workers were moving to the fields for fairly steady employment. Many of the workers were employed in the county, but some were transported to Palm Beach, Glades, Hendry, Okeechobee, and St. Lucie counties, depending on the need of the day. Since housing facilities at the few labor camps in the county are primarily available to full-time employers, the migrants were not housed at these locations but were absorbed in the Booker Park area. There seemed to be two groups of migrants; one consisted of single males living in rooming houses, and the other of family groups living in houses or apartments. It was noted on June 1 that many of the single males and family groups were making preparations to leave. The movement seemed to be up the East coast into Georgia and South Carolina where the next harvesting of crops would soon begin.

The estimated number of migrants at the peak of the season (November to May) is 1,100. About 400 of this number are workers with 700 non-working family dependents. The majority of these people have a Mexican background and come from the southeastern part of Texas around Cameron County. A few are Puerto Ricans and the remainder are Negroes. They are mostly families with young children. Few heads of families are over fifty years of age. They start to arrive in October and by June 1 the majority of them are gone. Those from Texas usually go to Michigan, Indiana, and states along that route before returning to Texas. Most Puerto Ricans and Negroes migrate along the East coast and work their way up to Maryland, Pennsylvania, and New York state. The families of many of the Negroes remain here and consider the local area "home," while the Mexicans usually take their families with them and often do not return to this area.

FAMILY HEALTH SERVICE CLINICS

During the period covered by this report, clinic sessions had not begun. The staff will consist of one part-time public health nurse, and one part-time clerk as of May, 1967.

Our first migrant clinic session will be held June 5, 1967 at the Keen Building, Indiantown, from 6:30 p.m. to 9:30 p.m. Vista volunteers will assist at the clinic.

The immunization clinics at the health department and rural areas have been and still are available to the migrants.

Individual counseling has been given regarding specific methods relating to family planning and referrals made to private physicians. Conferences with parents or responsible adults relating to basic health education, infant care, good nutrition, the value of intestinal parasite control, and family spacing have contributed greatly to the establishment of communications with the migrants.

The nurse visited Palm Beach County Health Department in April to observe a migrant clinic session as a means of orientation to this project.

Migrant health status needs improvement. We do not render medical care in the health department. Patients are referred to private physicians for care. We anticipate that the present burden that migrants put on the emergency room and the hospital will be reduced when we initiate our migrant clinic in Indiantown, as the clinic will be rendering comprehensive medical care. We are hopeful that money will be included in our coming budget of 1968 for payment of hospital bills which will benefit the hospital, the migrant, and the paying patient who lives in the community.

Working relationships were established with school personnel, physicians, church groups, and the press - as well as those people in other Federal projects such as the Vists volunteers, Homemaking Aids, and American Friends. These people and groups of people made migrants aware of what services we plan to offer them. Notices regarding opening of the clinics were sent home with school children in both Spanish and English.

NURSING SERVICES IN CAMPS OR OTHER PLACES WHERE MIGRANTS LIVE IN THE PROJECT AREA

No staff members were employed prior to May, 1967. There is one licensed camp and five major concentrations of migrant housing within the project area. Most of these are close to the clinic in Indiantown.

The number of conditions found requiring care is not available at this time as the health department records do not reflect this breakdown.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

A part-time sanitarian position was planned for this migrant program. To date, no one has been available for employment; therefore, the only work performed was by the staff sanitarians of the health department.

In the Booker Park area of Indiantown, where the majority of the migrants in the county live, housing, garbage and trash disposal, food service facilities, water supplies and sewage disposal systems, are investigated or inspected on an on-going basis by the sanitarians.

The labor camps are visited on a routine basis with water supply, garbage disposal, housing facilities, and sewage disposal systems being inspected.

Investigations over a period of time have indicated that there is a small percentage of the overall migrant population living in labor camps. The major camps in the county have constructed housing facilities for their full-time employees but have never been too successful in holding the migrant this far removed from the social activity of Booker Park.

Several of the citrus interests that are presently developing new groves, have encouraged the construction of housing facilities in Booker Park, rather than construct housing at the grove. They have agreed to rent a number of existing units on a seasonal basis. This guarantees the owner or developer a fixed income.

At the present time there are no regulations to eliminate substandard housing. There is a County Building Department that uses the Southern Standard Building Code as a guide. All new construction is inspected and must be approved prior to occupancy. Although there are very few substandard buildings being phased out, all new buildings are being constructed under supervision. As the area grows and the need arises, more and more new buildings are evident.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

We have been unable to fill the sanitarian position due to the shortage of sanitarians. Continued efforts will be made to fill this position.

Some difficulty was experienced when the doctor who agreed to fill the clinician position notified he would not participate in the program. After discussion he did agree to carry out his commitment if a second doctor would participate in the program. A second physician has agreed to participate in the program.

We had problems in recruiting staff. The months of March and April were spent in obtaining a building, obtaining supplies and equipment, and securing a nurse.

The local Soroptomist Club has taken the migrant clinic as one of their projects for this year. The individuals of this club provided all the furniture - desks, chairs, cabinets, tables, typewriter, refrigerator, etc. We will be receiving more help from them as it is needed.

The project starting date was changed from January 1, 1967 to March 1, 1967 at the direction of the U. S. Public Health Service.

PROJECT OBJECTIVES

Since the Martin County project did not actually begin operation by May 1, 1967, the objectives basically remain the same as in the initial application.

With facilities now available to meet the migrants' medical and dental needs, accomplishment of these services is our primary objective. The project objectives are:

(1) To make comprehensive medical care available to the migrant population.

(2) To make dental services, primarily emergency care, available to the migrant population.

(3) To increase existing nursing services available to the migrant population.

(4) To upgrade the environmental health of the migrant population.

OBJECTIVE #1

Medical care will soon be available through the clinic and on a referral basis. In the future we hope to make the migrant aware of his medical needs and provide services to meet these needs. Necessary medications will be available to the migrant patients at the clinic and by referrals to pharmacists.

OBJECTIVE #2

Dental clinics will be held during the same hours as the medical clinics. Services to be rendered will be primarily of an emergency nature - extraction and fillings. A fee-for-service system will be effected on a referral basis. Referrals to specialists may be made by the dentists. Prescriptions for dental patients will be processed by the pharmacists as prescriptions by physicians.

OBJECTIVE #3

A part-time public health nurse will soon be employed to work with the migrants. She will devote her time to the clinics, migrant school health, follow-up visits, home visits, health education activities, eligibility investigations, referrals, etc. The need is so great in this area, it is expected that this will become a full-time position.

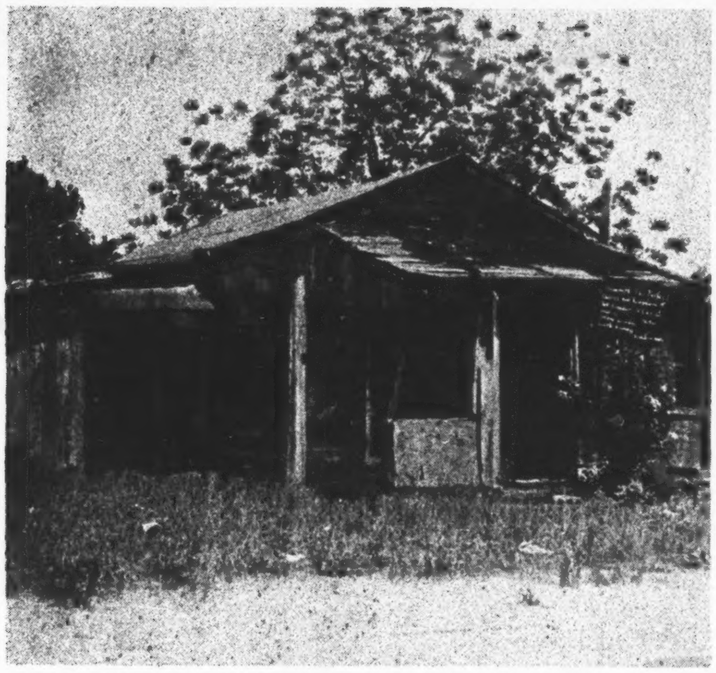
OBJECTIVE #4

It has been impossible to employ a part-time sanitarian for this project. Since the environmental health of the migrant is of utmost importance to his well-being, it is of vital importance to the success of the Migrant Project in this county to secure the service of a sanitarian. His duties would include health education; water sampling; septic tank inspections; housing surveys; rodent and pest control; conferences with growers, landlords, migrants, and others to improve living conditions. There is a definite need for this type of service in the county and it must be carried on if the illnesses attributable to an unhealthy environment are to be reduced. It defeats the medical program to treat and cure the migrants' ills if they are to return to an environment which caused their illness initially.

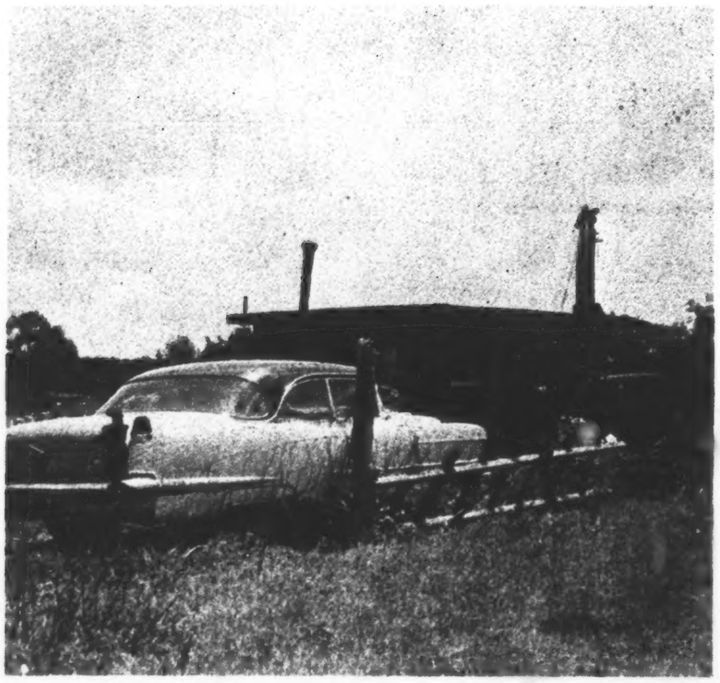
OBJECTIVE #4 - Continued

There is a definite need for a full-time sanitarian. It is hoped that this request will be approved and that it will not be so difficult to find a full-time employee.

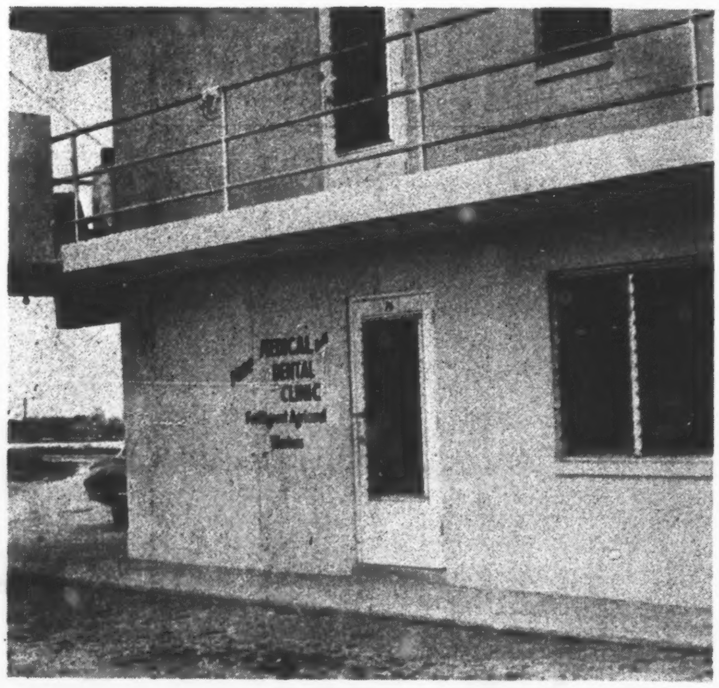
Migrant grocery store, Indiantown area, Martin County.



Migrant residence used as church, Indiantown, Martin County.



Migrant housing, Indiantown area, Martin County.



Migrant Health Clinic, Indiantown area, Martin County.

ORANGE COUNTY HEALTH DEPARTMENT

Wilfred N. Sisk, M. D., Director

Area of County: 916 square miles

Resident Population: 297,000

Number of Migrants: 10,000

Migrant Project Staff:
- 3 Public Health Nurses
- 1 Sanitarian
- 1 Clerk-Typist
- 1 Clinic Aide

ANNUAL PROGRESS REPORT - MIGRANT PROJECT

ORANGE COUNTY, FLORIDA

During the year 1966-67 we feel we have made progress on our planned objectives for this year. The population of migrant farm workers remains approximately the same as last year - 3,000 migrant farm workers with approximately 7,000 dependents; total 10,000.

A number of migrants continue to come in and out of the county during summer months. Most of our migrant families live in all parts of the county but the majority live in the northwest and west sections of the county. A large number of the dependents remain in Orange County during the summer while men in the families migrate North.

The arrival of migrants into Orange County varies from September to November, reaching the peak in November, 1966.

PROJECT OBJECTIVES FOR ORANGE COUNTY

The objectives for the past year were to continue to improve our services to the migrants with greater emphasis and follow-up on family planning, health hygiene and good nutrition during prenatal and postpartum periods. More emphasis to be placed on immunizations, and to include measles.

DOMESTIC AGRICULTURAL MIGRANT SITUATION IN PROJECT AREA

Approximately 3,310 migrants have received health and medical services during the 1966-1967 year, excluding those seen in the immunization clinics. These alone represent approximately one-third of the estimated 10,000 migrants in this area. Several hundred migrants, usually women and children, remain in this area when the male migrates "upstream." These migrants receive continuous service year round.

In all our migrant morbidity clinics, we offer complete screening, including blood pressure, serology, blood sugar or dextrostix testing for blood sugar, PPD testing, immunizations, pelvic examinations, pap smears, physical examinations, and x-rays upon physician's request (as our x-ray unit is in our main office and not in the outlying areas).

Nutrition information and health education are given to the best of the public health nurse's ability, using audio-visual aids, diagrams and leaflets, for relating facts concerning immunizations, planned parenthood, communicable diseases, good health and hygiene habits.

Maternal and child care clinics are available to all migrant families who wish to avail themselves of these services. We have established (and the program is in full operation) a program of family planning services. We feel that good results are being achieved from these services even earlier than we had anticipated.

STAFF PERSONNEL:

(1) Sanitarian (1) - 100% time
Sanitarians (10) - 5% to 15% time

(2) Public Health Nursing Supervisor (1) - 50% time

(3) Public Health Nurses (3) - 100% time
Public Health Nurses (20) - 5% to 20% time

(4) Physicians (1) - Part-time Clinic Physician
Physicians (1) -

(5) Clinic Aide (1) - 100% time (*)

(6) Clerk-Typist II (1) - 100% time (*)

(*) Positions will be filled in 1966-1967

FAMILY AND NURSING HEALTH SERVICE CLINICS

A part-time doctor conducts the Migrant Medical Clinics (Morbidity Clinics). The attendance at Winter Garden Migrant Clinic has been very good and this clinic is open during the summer months for migrants and their dependents. We have one evening clinic in Zellwood. In the other general clinics attended by migrants, resident physicians from the local hospital, a private Gyn physician, one Maternal and Infant Care Project physician and the Assistant Health Officer see the patients.

We now have a Family Planning Clinic available at Winter Garden and Apopka where contraceptive pills and intrauterine devices are available. We have a physician on the Tuberculosis Project available at the Apopka General Clinic.

Most of the clinics in Winter Garden and Apopka offices are generalized, combination clinics serving all the family members, such as: Maternity, immunizations, child health conferences, family planning (child spacing), tuberculosis, and venereal disease. The arrangement has been time-saving to the families, requiring less repeat visits.

These clinics are open 8:00 a.m. to 4:00 p.m. two days a week in Apopka, one-and-a-half days in Winter Garden, plus a half day being devoted to Migrant Morbidity Clinics.

During the project period there were 90 patients referred to other agencies, hospitals, doctors, etc., for conditions that could not be treated in the health department clinics or that required services that were not available.

Referrals made to:	No. Referred:
Hospital	7
Welfare Departments	16
Other Health Department Clinics	10
High Risk Maternity Clinic	30
Private Physicians	6
Dental Clinic	1
Tumor Clinic	3
Florida Council for the Blind	8
Florida Crippled Children's Commission	6
Sunland Training Center	2
National Polio Foundation	1

For the 1966 - 67 season a total of 1,808 home visits were made to migrant patients.

Area of Service:	No. of Visits:
Maternity	406
Child Health	862
Family Planning	136
TBC	176
Communicable Disease	10
Chronic Disease	143
Mental Health	59
Morbidity	16

A public health nursing supervisor devotes approximately 50 per cent of her time to the Migrant Program. Three project public health nurses assume the main responsibility for care to the migrant patients. Along with these nurses, eight other staff nurses (not assigned to the Migrant Project) assist with the care and follow-up to the migrants. The nurses furnish approximately 10 - 25 per cent of their time. The remaining 12 of the staff nurses assisting with the care of the migrants furnish approximately ten per cent of their time.

A sample of referrals made, using the Migrant Health Service Referrals, is listed. This represents approximately 50 per cent of the total referrals. In Orange County we have found that the greatest problem in making out-of-state referrals is that the majority of patients do not know exactly where they are going when the leave here; thus, the patient location information is sometimes incomplete. Frequently the only available address is the town and state. We have received many referrals from other states lacking this information also, so we realize how difficult it is to find some of these patients if they do not request services from the health department.

The areas needing improvement when completing the Migrant Health Service Referral appear to be:

(1) Patient location information, including crew leader's name and approximate time of arrival.

(2) Camp going to.

(3) Employer's name.

REFERRALS OUT

STATE	NO. SENT	NO. COMPLETED
Minnesota	1	
Alabama	1	
Michigan	3	1
Ohio	2	
Georgia	3	1
New York	9	6
Florida	6	2
Washington, D. C.	3	2
Maryland	1	
Missouri	1	1
TOTALS	30	13

REFERRALS IN

Ohio	1	1
New Jersey	6	5
New York	7	6

REFERRALS IN (Continued)

Delaware	1	
Virginia	2	1
Florida	2	1
TOTALS	19	14

REFERRALS OUT

SERVICES	0 - 14 Years	15 - 44 Years	45+ Years
Child spacing		1	
Pap, Family Planning, Immunization, PP		1	
Health appraisal, Immunization	1		
Family Planning		1	
Pap, Family Planning		1	
Health Appraisal, Immunization	1		
Family Planning		1	
PP and VD		1	
Family Planning		1	
Family Planning, Health appointment, Immunization, Nutrition		1	
Antepartum		1	
Chest x-ray, Health appointment, Immunization		1	
Health appraisal, Immunization	1		
Family Planning		1	
Antepartum		1	
Antepartum		1	
Antepartum		1	
Antepartum		1	
Family Planning, Health Appraisal		1	

REFERRALS OUT - SERVICES (Continued)	0 - 14	15 - 44	45+
Health appraisal, Immunization, Nutrition	1		
Health appraisal, Immunization, Nutrition	1		
Health appraisal, Immunization, Nutrition	1		
Antepartum		1	
Health appraisal	1		
Family Planning		1	
Family Planning, Health appraisal, Immunization		1	
Family Planning, Health appraisal, Immunization		1	

REFERRALS IN

SERVICES	0 - 14 Years	15 - 44 Years	45+ Years
Prenatal		1	
Health appraisal			1
Chest x-ray		1	
Chest x-ray		1	
Health appraisal			1
Health appraisal		1	
Health appraisal			1
Prenatal		1	
Health appraisal	1		
Health appraisal		1	
Health appraisal	1		
Vocational rehabilitation	1		
Antepartum		1	
Chest x-ray, AP		1	

REFERRALS IN - SERVICES (Continued)	0 - 14	15 - 44	45+
Health appraisal, Immunization	1		
Child spacing, PP		1	
Family Blanning		1	
Chest x-ray			1
Family Planning		1	

The health education services to the migrant population of Orange County are handled largely by the public health nursing staff.

They provide individual counseling to patients regarding nutrition, immunization needs, communicable disease control, infant care, prenatal care, and family planning. They also give group instruction on prenatal care, infant care, and family planning. The number of persons reached is included in the nursing section of this report.

In addition to working with the migrants, the public health nursing field supervisor on the Migrant Project conducted two short courses for the Migrant Ministry. They were trained in clinic procedures and in the intake of patients and now assist in the migrant clinics.

As part of their health department orientation all public health nurses are given orientation to the Migrant Project. These nurses then act as health educators and instruct patients.

We have some difficulty in impressing upon the migrants the importance of giving us a forwarding address when the leave Orange County. We are trying to overcome this by asking that they send us their address as soon as they are settled in a new location.

Another problem has been lack of motivation on the part of the migrant workers. We have provided night clinics in a convenient location to make it easier for them to take advantage of our services.

We are using a series of pamphlets, prepared for the Migrant Project. We find them simple, informative, and effective for use with the migrant workers.

We would like to interest community groups in the Migrant Project in the hope that they could work with the health department in providing services to the migrants.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

I. STAFF

A. Number full-time by type.

One sanitarian

B. Number part-time by type.

Same as above, except all sanitation staff assists in program.

II. LOCATION OF CAMPS WITHIN PROJECT AREA

Labor camps in Orange County are located in the western and northwestern sections of the county, primarily in the Windermere, Winter Garden, and Apopka areas.

III. LAWS, REGULATIONS OR OTHER CRITERIA FOR EVALUATION OF CAMPS

Sanitary Code, Chapter 170C-32 is used for evaluation of camps.

IV. NUMBER OF CAMPS IN AREA BY SIZE AND TYPE OF OCCUPANCY

A. Harlem Heights

1. Capacity 900
2. Present occupancy consists of single males, some families in apartments, some off-shore labor at present time.

B. Reddick's Labor Camp

1. Capacity 325
2. Present occupancy consists of single males and families.

C. Granada Labor Camp

1. Capacity 294
2. Present occupancy single males, mostly domestic, some off-shore labor at present time.

D. Isleworth Labor Camp

1. Capacity 18
2. Present occupancy single males.

E. Zellwood Labor Camp

1. Capacity 60
2. Present occupancy single males, families.

F. Jimmy's Labor Camp

1. Capacity 40
2. Present occupancy single males.

G. DeNees Labor Camp

1. Capacity - Unknown (To be relicensed)

H. Tucker's Labor Camp

1. Capacity - Unknown (To be relicensed)

V. SANITATION SERVICES RELATED TO CAMPS

A. Total number of camp visits made during project period by purpose of visit.
Total number of camps visited during project period.

1. Camp visits from daily reports.

B. Number of camps which met existing standards at beginning of season.
Number of camps brought up to standard during project period.
Number of camps which met standards at end of season.

1. All camps met existing standards at beginning of season. Six camps total. One out of six not meeting standards at end of season, but in the process of being brought up to standards at present time.

C. Number of defects found by type:

1. Garbage	120
2. Sewage	41
3. Water supply	4
4. Heating	4
5. Screening	16

Number of defects corrected by type:

1. Garbage	103
2. Sewage	38
3. Water supply	4
4. Heating	4
5. Screening	10

D. Chief methods used in obtaining correction of defects. Reasons, or opinions regarding reasons for failure to obtain correction of defects which remain.

1. Complete periodic inspections were made during the year and defects found at these various times were discussed with camp owner or manager. In most cases, defects have been corrected by camp owners, but lack of supervision and education of migrants results in a rapid return of insanitary conditions.

VI. OTHER TYPES OF HOUSING USED BY MIGRANTS MOVING INTO PROJECT AREA OR LEAVING IT TEMPORARILY FOR SEASONAL WORK IN CROPS, BY TYPE OF HOUSING, MAJOR LOCATIONS, AND ESTIMATED NUMBER OF PERSONS HOUSED AT EACH MAJOR LOCATION.

Many families in our domestic labor force rent existing housing of all types in areas nearest to their work. The majority of our domestic labor are renting housing in the community other than labor camps.

VII. LAWS, REGULATIONS OR OTHER CRITERIA FOR EVALUATING HOUSING NOT LOCATED IN CAMPS.

Rules and regulations are the same as for any other citizen living in any private community.

VIII. SANITATION SERVICES RELATED TO MIGRANT HOUSING OUTSIDE OF CAMPS.

All sanitarians spend a portion of their time in all types of environmental health work in those areas of the community with migrant workers.

A. Total number of visits made to other than camp locations by purpose of visits:

1. Complaints - 72
2. Water supplies - 12

B. Total number of locations visited:

1. 56 locations visited.

C. Total number of housing units visited at these locations:

1. 43 housing units visited.

D. Number of housing units which met existing standards at beginning of season:

1. 27 housing units up to standards.

E. Number brought up to standard during project period:

1. Eight brought up to standards during project period.

F. Number meeting standard at end of season:

1. 33 meeting standards at end of season.

G. Number of defects found by type:

1. Water supplies - 10
2. Sewage disposal systems - 23
3. Mosquito breeding - 8
4. Privies - 3

H. Number of defects corrected by type:

1. Water supplies - 8
2. Sewage disposal systems - 23

3. Mosquito breeding - 5

4. Privies - 3

I. Chief methods used in obtaining correction of defects:

1. Issuance of sanitary nuisance notices or correction notices to landlords.

J. Reasons, or opinions regarding reasons for failure to obtain correction of defects which remain:

1. Owners reluctance to invest or owners lack of funds to correct.

K. Comparative data available from previous years:

1. Less defects found and corrected this year compared with last year.

IX. NUMBER OF FIELD LOCATIONS VISITED DURING CROP SEASON COMPARED WITH ESTIMATE OF TOTAL NUMBER OF FIELD LOCATIONS WHERE MIGRANTS ARE EMPLOYED.
TOTAL NUMBER OF FIELD VISITS CONCERNED WITH FIELD SANITATION MADE THROUGHOUT SEASON.

A. Field location visits - 32
Estimate of total number of field locations - 350

B. Field visits for sanitation - 130

X. NUMBER OF FIELD LOCATIONS BY SOURCE OF WATER SUPPLY USED FOR DRINKING WATER; FOR HANDWASHING.

A. 15 sources of water.

B. Defects observed by number and type:

1. Method of transportation and distribution - 46

C. Defects corrected by number and type:

1. 33 defects corrected.

D. Problems in obtaining correction of defects and ways in which problems were overcome:

1. Purchase and installation of approved water dispensers.

E. Problems not overcome and opinion regarding reasons:

1. Difficulty in getting management to expend funds. Single service cups and sanitizing of containers difficult.

XI. NUMBER OF FIELD LOCATIONS BY METHOD OF WASTE DISPOSAL.

A. Field locations - privies. 32 reviews of waste disposals.

B. Defects observed by number and type:

1. 18 improperly consturcted insanitary privies.

C. Defects corrected by number and type:

1. 14 corrections of above.

D. Problems in obtaining correction of defects and ways in which problems were overcome:

1. Improper construction of privies, poor maintenance, temporary locations.

E. Problems not overcome and opinion regarding reasons:

1. Construction of privies not properly built still remain on field locations.

XII. LAWS, REGULATIONS, OR OTHER CRITERIA USED IN EVALUATING FIELD SANITATION.

Florida State Board of Health, Chapter 170C-32.

XIII. EXAMPLES OF PURPOSES AND METHODS OF EDUCATIONAL EFFORT.

A. With migrants:

1. Migrant education; personal contact, explaining why rules and regulations must be enforced in camps and public housing.

B. With growers, camp managers, etc.:

1. Growers, employer; discussions regarding maintenance and rebuilding of camps and housing.

C. With other persons or groups:

1. Other group education; city administrations where density of population contains numerous migrant housing areas.

XIV. NUMBER OF PERSONS GIVEN INDIVIDUAL COUNSELING ON SPECIFIC PROBLEMS BY TYPE OF PROBLEM.

A. 18 owners of housing, sanitary facility requirements.

B. 63 owners of food service in migrant areas.

C. 4 ministers concerned with housing and food.

D. 2 utility companies regarding service.

XV. NUMBER OF PERSONS COUNSELED ON A GROUP BASIS BY TYPE OF PROBLEM, BY TYPE OF GROUP, AND NUMBER OF SESSIONS FOR EACH.

Most counseling by individual rather than group. Over 200 individuals directly contacted about sewage disposal, water supply, and garbage control.

XVI. TYPES OF INDIVIDUALS AND GROUPS WITH WHOM WORKING RELATIONSHIPS WERE ESTABLISHED AND PURPOSES OF RELATIONSHIPS.

Have established working relationships with public health nurses, crew leaders, ministers, and church workers. Purpose has been to enlist their aid in eliminating a particular sanitary problem in the camp and to report to them any problem that relates to their particular field.

XVII. PROVISION MADE FOR ORIENTATION, IN-SERVICE TRAINING, OR OTHER INDOCTRINATION OF PAID OR VOLUNTEER STAFF, OR OTHER PERSONS INVOLVED IN ACTIVITIES TO IMPROVE HOUSING AND SANITATION.

Orientation, in-service training, and indoctrination discussions held with county building department, plumbing inspector, and zoning board. All sanitarians have been trained in migrant review. In-service training of labor camp managers and grounds personnel.

XVIII. PROBLEMS WHICH PREVENT OR HINDER GROWERS (OR OTHER OWNERS) IN MAKING IMPROVEMENTS IN HOUSING AND FIELD SANITATION; WAYS IN WHICH PROBLEMS HAVE BEEN MET; REASONS, IF NO WAY TO MEET PROBLEMS CAN BE IDENTIFIED.

A. Problems - Improvements - Low cost of living and low income, plus seasonal work hinders the improvement program in migrant housing.

PROBLEMS WHICH PREVENT OR HINDER GROWERS (OR OTHER OWNERS) IN PROPER MAINTENANCE OF FACILITIES WHICH HAVE BEEN BROUGHT UP TO STANDARD; WAYS IN WHICH PROBLEMS HAVE BEEN MET; REASONS, IF THERE IS NO APPARENT WAY TO MEET PROBLEMS.

B. Problem - Maintenance is difficult because of lack of education and knowledge of facilities by workers. Problem - Migrants - the proper care and use of facilities by workers is almost entirely lacking.

PROBLEMS WHICH PREVENT OR HINDER MIGRANTS IN MAINTAINING OR MAKING PROPER USE OF HOUSING OR FIELD SANITATION FACILITIES.

Same as "B" above.

OTHER PROBLEMS IN PROJECT OPERATION.

C. Indifference of workers regarding property of others and actual destruction by users is a big problem. Cleaning up after temporary occupancy is also a problem. Care of grounds to prevent littering is a problem.

XIX. GENERAL APPRAISAL OF RESULTS OF SANITATION SERVICE - EVIDENCE REGARDING:

A. Migrants' understanding and acceptance of responsibility for improvement of their own practices in the use of housing and field facilities:

1. The domestic migrant and family units are not maintaining a standard of living as high as the off-shore workers. In most instances our migrant worker is not accepting responsibility for improving or even maintaining housing facilities in an acceptable way.

B. Camp and other owners' acceptance of responsibility for providing and maintaining facilities in an acceptable way:

Community understanding of the situation, relationships, and attitudes.

1. Camp owners have been willing to provide and maintain decent facilities but in many cases they have become discouraged because of constant damage and abuse of property by migrants.

C. Grower-migrant relationships, willingness of migrants to stay throughout the season, etc.:

1. There is a growing problem in keeping domestic workers on the job.

D. Disease conditions attributable to poor housing and sanitation:

1. The incidence of disease and general illness has been higher in the camps, the poorer housing and areas of insanitary conditions.

XX. GENERAL APPRAISAL OF ADEQUACY OF SERVICES.

A. Was it possible to serve all camps and other housing locations in the project area? If not, why?

1. Because of scattered housing it is not possible to know whether all persons have been contacted or all problems discussed. All camps have had adequate inspections.

B. Were needs for health education met? If not, why?

1. Health education is difficult to promote at best except in camps, where efforts are made in clinics and by hand-outs to improve sanitation.

XXI. SPECIFIC INFORMATION AND SUGGESTIONS BASED ON THIS SEASON'S EXPERIENCE THAT WOULD BE HELPFUL IN FUTURE OPERATION OF THIS PROJECT, OR HELPFUL TO OTHERS IN PLANNING HOUSING OR FIELD SANITATION PROGRAMS IN KNOWING WHAT TO PLAN FOR, AND HOW TO CONDUCT A PROGRAM.

The trend for the past several years has been from a barracks type housing of men to apartment type family housing. Thus this new trend has brought a whole new set of problems; that is, welfare of children (schooling, health and general safety), less control over family type dwellings as regards general sanitation and health. The need is for education of the workers relating to everyday living and more civic effort of various groups to assist the migrant families.

MEDICAL AND NURSING

May 1, 1966 through April 30, 1967

FAMILY HEALTH SERVICES

Type of Clinic	Sessions		Hours in Clinic		Patient Visits
	M.D.	PHN	M.D.	PHN	
Morbidity	101	101	247½	Not broken down	
General Clinics i.e., Maternity, Child Health Conferences, TBC, V.D., where Migrant patients attended.	200	200	802	5,763½	
Immunization Clinics		186		372	
TOTAL patient attendance for morbidity and general clinics					3,310
Return visit attendance					2,286
TOTAL patient attendance in Immunization Clinics					6,035
TOTAL	301	487	1,049½	6,135½	9,345

Physician Services to Patients ------------------------------------ 2,871

Nursing Services to Patients ------------------------------------ 9,345

Each individual seen in the clinic was interviewed by the public health nurse and counseled on his/her specific problem at that particular time. Patients returned to clinic if another condition arose and re-evaluation is done with counseling by the nurse for each specific problem.

IMMUNIZATIONS

May 1, 1966 Thru April 30, 1967

	-1 Year	1 Thru 4 Years	5 Years and Over	Boosters & Revaccination	TOTALS
SMALLPOX	58	69	42	65	234
DIPTHERIA					
Completes	207	134	215	519	1,075
Incompletes	331	251	200	0	782
WHOOPING COUGH					
Completes	207	129	80	287	703
Incompletes	374	247	123	0	744
TETANUS					
Completes	212	136	223	536	1,107
Incompletes	376	254	232	0	862
POLIO					
Completes	50	169	174	1,028	1,421
Incompletes	143	225	219	0	587
TYPHOID					
Completes	17	107	63	183	370
Incompletes	26	176	125	0	327
MEASLES					
Complete	31	81	15	0	127
INFLUENZA					
Complete	0	0	42	0	42

MIGRANT REPORT

CONDITION	SEX	AGE 0 - 1	AGE 1 - 4	AGE 5 - 15	AGE 15 - 44	AGE 44 +	TOTAL
ALLERGY	MALE	1	1	1			3
	FEMALE	1		1	3		5
ANEMIA	MALE	7	12	9	9		37
	FEMALE	3	16	7	10		36
ARTHRITIS	MALE						
	FEMALE				1	2	3
ASTHMA	MALE			8	13		21
	FEMALE	1	1		32		34
BURNS	MALE				1		1
	FEMALE	1	1				2
CHILD HEALTH SUPERVISION	MALE	210	84	87	12		393
	FEMALE	202	93	68	6		369
CHILD SPACING	FEMALE				878	3	881
COMMUNICABLE DISEASE	MALE						
	FEMALE		1				1
CARDIO-VAS. DISEASE	MALE	1		6	3	2	12
	FEMALE	3		43		19	65
DENTAL	MALE			1	1		2
	FEMALE			3	4		7
DIABETES	MALE					3	3
	FEMALE				5	1	6
EAR, NOSE & THROAT	MALE	5	6	7	3	2	23
	FEMALE	4	9	12	5	1	31
EPILEPSY	MALE		2	7			9
	FEMALE		1			1	2
EYE	MALE	3	3	12	2	1	21
	FEMALE	4	4	5	5		18
GASTRO-INTEST.	MALE	4	2		8	3	17
	FEMALE	7		3	11	5	26
GENITAL-URINARY	MALE	1			4		5
	FEMALE	1		1	12		14
GYN	FEMALE			5	27		32

CONDITION	SEX	AGE 0 - 1	AGE 1 - 4	AGE 5 - 15	AGE 15 - 44	AGE 44 +	TOTAL
HERNIA	MALE				1		1
	FEMALE	2			1		3
INTESTINAL PARASITES	MALE		12	7			19
	FEMALE	1	5	10	2		18
MATERNITY	FEMALE			33	1233		1266
MENTAL RETARDATION	MALE		1	5			6
	FEMALE						
NERVOUSNESS	MALE						
	FEMALE			1	2		3
NEURO	MALE				9	3	12
	FEMALE				27	12	39
OBESITY	MALE						
	FEMALE				1		1
ORTHOPEDIC	MALE		2	2	5		9
	FEMALE	1	2	1	9	1	14
PSYCHIATRY	MALE		1	5	1		7
	FEMALE				2	3	5
SKIN	MALE	14	29	8	9	3	63
	FEMALE	11	31	17	12	2	73
TBC	MALE			3	5	2	10
	FEMALE	1	1	5	6	2	15
TRAUMA	MALE	1	1	2			4
	FEMALE		1	2	3	2	8
TUMOR	MALE						
	FEMALE					1	1
UPPER RESP. INFECT.	MALE	14	22	11	7	3	57
	FEMALE	15	27	12	17		71
VENEREAL DISEASE	MALE			3	31		34
	FEMALE			3	5		8

POLK COUNTY HEALTH DEPARTMENT

William F. Hill, Jr., M. D., Director

Area of County:	1,861 square miles
Resident Population:	212,000
Number of Migrants:	20,000
Migrant Project Staff:	2 Public Health Nurses 1 Senior Sanitarian

POLK COUNTY MIGRANT PROJECT REPORT

May 1, 1966 to April 30, 1967

NURSING DIVISION

The coordination and provision of health services for migrants as a selected group in Polk County remains largely an unmet objective fraught with many questions.

The 20,000 persons classified as migrants, by the definition for this program, remains fairly constant from year to year with a slight downward trend in total number. Changes within the 20,000 migrant population are identifiable when viewed over a period of several years. During the past five years, the following changes have become apparent in this county:

- Fewer women and children are going north with the men.
- More migrant families are investing in real property and staying here for a longer period of time.
- The number of Spanish-speaking families has increased markedly in the past two years - from approximately 20 families known to us two years ago to 100 or more now. These people too are buying small houses.
- The "in-migrants" were fewer in number during the "season" now ending and stayed a shorter length of time necessitating the importation of some off-shore labor to harvest the Valencia crop.

The next five years will probably show an acceleration of the downward trend in the number of "in-migrants" due to decreasing acreage within the county used for citrus and to the development of more mechanized picking methods.

Migrants in the county are disseminated among the general population of the county that lives on 3/4's of the land area or about 1,500 square miles. Due to this distribution of the target group, it is not possible to assign personnel to work with them exclusively or to establish and maintain separate facilities for their care. Services are available in eight health department centers five days a week, staffed by thirty public health nurses and two health department physicians who divide their time between stations. In addition to these medical services, four private physicians work in health department clinics from ten to twelve hours per week.

Project funds allocated to pay for two nurses, some medical time and some clinic supplies allow us to give limited treatment and nursing time which we could not otherwise furnish. During the past year we have made continued effort to seek these people out, help them to recognize their health needs, and inform them of available services both in our department and through other agencies in the county. Through this effort services have been increased slightly during the past year without additional funds or personnel.

The following table reflects this difference in key selected activities between the year ending April 30, 1966 and April 30, 1967:

Key Activity	1967	1966	% of Increase or Decrease
VD Treatments	35	17	+105%
Cases of TB Admitted	37	25	+ 48%
Immunization Series Completed (all types)	5140	7620	- 32%
Maternity Patients Admitted to Medical Service	168	122	+ 37%
Post-Partum Medical Examinations and Pap Smears	107	90	+ 18%
Patients Admitted to Maternity Nursing Service	234	178	+ 31%
Nursing Visits to Maternity Patients	1318	1176	+ 12%
Patients Admitted and Furnished with Contraceptive Materials & Info.	198	138	+ 43%
Children Admitted to Medical Services	141	253	- 44% *
Children Given Medical Care	321	343	- 6% *
Children Admitted to Nursing Service	597	548	+ 8%
Nursing Visits to Children	1999	1840	+ 8%
Adults Treated for Acute Illnesses	151	124	+ 21%
Nursing Visits for Acute Illnesses in Adults	237	223	+ 1%
Patients Admitted to Chronic Disease Service	57	52	+ 9%
Nursing Visits for Chronic Illness	170	116	+ 46%

No method has been devised for accurately accounting for the time and effort involved or results obtained when patients are referred to other agencies or to private physicians. The clerical time involved in gathering this information makes any plan prohibitive when all programs carried on by the health department are considered. During any month the percentage of total nursing time spent in service to this segment of the population far exceeds the percentage of time paid for by project funds. Therefore, while the service furnished this group may not approach the ideal, it is felt that the best possible use is being made of funds received.

(*) For eight months out of the year covered by this report the department was without a medical director who had assisted with the clinics.

Migrant Health Referral Forms designed several years ago are being used with reasonable success. It seems that the greatest failure in the use of such records is due to the stage of cultural development occupied by these people. They are unable as yet to see the need for planning ahead and therefore are unable to cooperate in follow-up procedures. For this reason and the lack of uniformity of services available in various states, we continue to give sufficient medication to last for several months before they leave this area.

In spite of considerable effort, no "fee-for-service" plan has been accepted by the medical community and the need for in-hospital care remains the greatest unmet need.

Without a greatly increased budget (perhaps 500%), it is doubtful whether the present program can be appreciably improved since the department is grossly understaffed to deliver comprehensive health service. The wisdom of implementing such a service, regardless of the project funds available for one segment of the medically indigent population, must also be seriously questioned.

DIVISION OF SANITATION

I. General Description of Sanitation Program

The health department in Polk County has completed two and one-half years of a Federal grant project. This year's "bumper crop" of citrus brought with it keen competition for labor. Consequently, we began to see an increased use of Texas Mexicans, combined with an abundant use of the southern Negro. Crew leaders, grove owners, and other industry representatives recruited labor anywhere it could be found. Many of these people had never picked citrus before; therefore, the rate of turnover was overwhelming. These problems were further complicated by these crew chiefs and owners contracting with individual hotels, motels, trailer courts, and apartments for migrant housing. To date we have no accurate way of knowing how many are served in this capacity.

A. Staff Involved

1. One full-time and five part-time sanitarians.
2. The time and effort to the local Ministerial Association and the Northeast Polk County Nursing Council have aided the sanitarians in the health education of the migrant.

B. Specific Duties

Professional - The importance of a general health program for the migrant is fully recognized. We are presently administering programs in all phases of environmental sanitation. The statistics below show some of the work accomplished:

90	camp inspections
56	new septic tank installations
10	new privies installed
15	school inspections
23	mobile home visits
33	child care center inspections

399 complaint investigations
184 nuisances corrected
151 rabies animal bite investigations
409 visits to eating and drinking establishments
188 visits to grocery stores and meat markets
256 private premises surveyed.

Others - Group meetings and discussions in basic hygiene helped convey to the migrant the proper care and use of domestic sanitary facilities.

C. Work to be Done

The sanitarian recognized the need for better communications, either through interpreters or additional language courses.

D. Relationships Established with and Involvement of Migrants

There was a definite increase in the relationship with those groups actively concerned with the migrants' well-being. Numerous meetings were held with home demonstration agents, labor division representatives, Northeast Polk County Ministerial Association, and the Bartow Migrant Christian Committee. The sanitarians also worked closely with teacher groups explaining the need for better basic hygiene in the home. Many of these people had never used the facilities of an indoor bathroom and, consequently, the need for training in basic hygiene had to be stressed.

E. Consultation Obtained from Outside the Project--Type and Source

The employment service maintained a separate office for migrant labor where the sanitarians were able to meet with individuals directly concerned with placing the migrants in specific locations throughout the county and discuss the environmental health program with them.

II. General Description and Condition of Housing Accommodations for Migrants

A. Camps - Polk County has twenty labor camps; thirteen of these are licensed, three are presently under construction, and the remaining four are currently undergoing changes to qualify for licensing. All camps are served by deep wells. The sanitarians are currently engaged in a program of stressing individual paper cups for drinking water in the field - eliminating the common cup. Sewage disposal facilities are inspected and approved. We continue to have a problem with refuse disposal at most of our camps. Through more rigid enforcement we have been able to secure centralized heating facilities, eliminating many "pot bellied" stoves. Food service, too, has been improved. Many of the camps are now contracting with commercial catering organizations to assume full responsibility for food service. Regretfully, none of our camps have any recreational facilities. We also noted better control of insect and rodents, which we feel is due to better management in food service.

B. Single and Family - Housing accommodations for the migrant are reflected in the extremes one finds in any given area. While much of the housing is clustered in small groups or communities, it nevertheless is scattered throughout the 1,861 square miles of the county. In discussing general housing conditions for migrants, we need to keep in mind that sanitary facilities may be adequate and approved for a given number of people, but the total number occupying the housing during harvest season may far exceed that for which it was designed.

Our surveys have disclosed an increased use of house trailers. They are jacked up, with the wheels removed, and clustered in many remote areas. We are also beginning to find pickup trucks with camper bodies parked in groves. These vehicles have no sanitary facilities whatsoever. Many of the private dwellings used by migrants continue to be substandard.

III. Where housing is grouped in small confines within city boundaries, it is usually served by public water, sewage, and refuse disposal. The unincorporated areas of the county continue to present the majority of the unsatisfactory waste disposal problems, coupled with the use of shallow driven wells as a water supply. Seventy-five per cent of private housing used by migrants is substandard, with the remaining twenty-five per cent unsatisfactory. We continue to cope with the problem of unsatisfactory food handling in the field. Foods are carried either by the individual worker or the family without regard to proper storage. There is no provision for proper food storage in the field.

Recreational facilities continue to be needed in camp areas.

IV. Efforts in Health Education

As previously outlined, we continue to be successful. Our relations with social and economic groups are becoming more close knit. We have begun to achieve a partial success in conveying to the migrant basic sanitation concepts.

V. General Appraisal of Program

There has been a general upgrading in the area of private housing. Camp sanitation also shows improvement. Interest and support of the project by local community groups has been of great help. An analysis of the overall program helps stress where improvement is needed.

A. Extent of Success

Our progress speaks for our success. Only through constant endeavor was the sanitarian able to successfully promote the adoption of the Southern Standard Minimum Housing Code within corporate limits. We continue to be plagued by the unreasonable burden placed upon us in promoting sanitation without the aid of county-wide zoning restrictions.

B. Description of Ways in which Corrections were Obtained

Educating the migrant in the use of basic sanitary facilities may seem outdated in this modern world of the Space Age, but nevertheless we needed to begin at the root of the problem. Many of the Mexican groups, along with the Negroes, have never seen or used modern-day facilities. They need instruction, not only in their use, but care and maintenance. Our whole concept of education in sanitation is aimed at eliminating many of the problems before they begin.

VI. Plans for the Future

Because of the competition for labor and the restricted use of off-shore workers, the growers utilized large numbers of Mexicans to aid in harvesting. It is generally accepted that more and more of this cultural group will be used in future seasons. We experienced difficulty in communicating without the use of an interpreter. A basic course in Spanish would be of tremendous help to the sanitarians. Additional methods are needed to bridge the language gap. A Spanish-speaking sanitarian aide would be helpful in administering our programs. The defeat of apathy and instillment of pride will do much to overcome many of our problems.

ADDENDUM

REFERENCES

Labor Force Estimates - Polk County

Migrant Labor Supply States - Mississippi, Alabama, Tennessee & Georgia

1966 - 1967 Citrus Processing Employment - 8,885

Source: G. M. Simmons
Florida State Employment Service
Winter Haven, Florida

Office Referral Migrant Housing - 200 to 250 families

Figures for labor recruited out-of-state by individual grower - not available

Migrant season population workers only - 3,500

Source: Paul Morton
Migrant Labor Division
Florida State Employment Service
Dundee, Florida

Citrus Acreage - 149,000

Fruit Harvest - 1 million boxes tangerines
17 million boxes early mid-season oranges
18 million boxes late season oranges

Labor Estimate - Harvest 4,000

Grove Production - 2,000 (loaders, drivers, etc.)

Number of Growers in Polk County - 2,000 to 2,500

Source: Polk County Agent's Office
Glen Haddock
Assistant County Agent
Bartow, Florida

HEALTH EDUCATION SERVICES

I. Staff

Staff members from the entire health department participated in health education services to migrants; however, the department employs only one health educator for specific health education duties. This staff member did give time to the Migrant Health Project

II. & III. Kinds of health education service provided and kinds of groups to which these services were provided. Examples of purposes and methods of education effort.

(A) Educational materials for migrants, published by the Florida State Board of Health, were distributed to the nine health centers for further distribution to patients. This provided motivation for immunizations and improved sanitation; information on family planning and prenatal care; and stressed the importance of patients going at once to the clinic for treatment of venereal diseases when they were contracted. Some of these materials on sanitation and diseases were given to the public schools which usually have migrants enrolled. The leaflet on Florida Sores was helpful. Educational materials on the need for treatment of intestinal parasites were also distributed.

(B) The film, "The Season People," was shown to the Polk County Dental Society; the Polk County Dietetic Association; the faculty of a public school; to fifth and sixth graders of two elementary schools; and to several church and civic groups. This was done in an effort to inform the citizens of Polk County of the plight of the migrants and to emphasize the importance of their services to the economy of Polk County.

(C) The health educator met with a staff writer from The Ledger, a Lakeland daily newspaper, who was interested in writing an article about migrants. This writer was given articles from the information file which is kept in the health education section of the health department. In addition, arrangements were made for the writer and a photographer to observe a clinic. The articles ran in a series in April, 1967. Some are attached.

(D) A film titled, "Baths and Babies," was secured on a permanent-loan basis from Johnson and Johnson for regular weekly showing at well-baby clinics.

(E) The health educator and other staff members realize that many migrants are not reached by the news media so much education was accomplished by the nurses and sanitarians by talking with migrants individually and in groups during home visits and in the clinics. Items discussed ranged from how to get rid of head lice to how to use the powdered milk which had been received from the Federal Donated Food Program.

(F) A workshop was held for public school teachers on venereal disease. Approximately 75 attended. V.D. was made a part of the junior-high curriculum.

IV. Number of persons given individual counseling on specific problems by type of problem. (Also see records of nurses and sanitarians.)

The health educator, who is also a nutritionist, estimated twelve persons were given individual diet instructions on diabetes; 10 received health information on venereal disease; 20 were given information on prenatal care and family planning; 5 received information on alcoholism.

V. Number of persons counseled on a group basis by type of problem, type of group, and number of sessions for each. Other groups - an estimate of 300 persons from professional, civic, school, and church groups. Type of problem - awareness that migrants exist and migrants' health needs.

VI. Working relationships established with the following and purpose:

(A) School teachers and principals - general information and health education for migrants.

(B) Polk County Extension Home Economics agents - Improvement of home life; better nutrition; importance of health care for migrants.

(C) Polk County Hospital - To inform new staff members of Polk County Health Department services which include services available to migrants. The program was done at the request of the social service director of the hospital.

(D) Polk County Christian Migrant Ministry - To inform members of available Polk County Health Department services for migrants.

(E) Professional, church, and civic groups - To inform these groups of services available to migrants and migrants' problems in obtaining services, such as transportation.

VII. Information concerning this item may be found in other sections of this report.

VIII. Problems which hindered effectiveness of educational effort: The biggest problem is staffing. There should be at least one health educator employed to work with migrants. This person could be available to visit the health centers and homes especially in Haines City, Waverly, and Lake Wales, on a regular basis for health education demonstrations, films, and talks with the migrants. The health educator found a well qualified person with a teaching certificate and a good background of working experience who wanted to do this type of work, but funds were not available in January and this person took a position in an elementary school at mid-term. Also, another staff person is needed to work out some of the techniques for reaching the migrant with health information. This person could help with the work now being done on prenatal instructions for the carrousel slide projector, which was received from the State Board of Health. The part-time services of a nutritionist are needed as poor nutrition and budgeting are common problems among migrant families.

IX. Factors which contributed to effectiveness in educational effort: The wonderful team effort toward education by the nurses in the generalized nursing program and the excellent cooperation of the sanitarians. The Polk County Health Department had a large "faculty" to help meet the educational needs of the migrants.

X. General appraisal of educational efforts: It will take time to evaluate any change in behavior of the migrant. Local residents do not seem to object to this type of Federal program as much as they have to some programs. This leads one to believe that there is an improved attitude on the part of some citizens. The persons who saw the film, "The Season People," were amazed at some of the problems the migrants face, as well as the problems of the health worker in meeting the health needs of the migrants.

XI. General appraisal of adequacy of health education services: It was impossible to reach all migrants because of the unique way they are interspersed in the general Polk County population of 215,000 persons, and because of the limited time of the health educator. The educational aids which were purchased with available funds have been very useful in the program and the staff is grateful to have these tools for a more effective educational program aimed at migrants. The flannel board, construction paper, and other materials have been most useful. The health educator considers the program worthwhile and would like funds for another health educator and more funds for educational aids. The opportunities are tremendous for more health education.

XII. What specific information or suggestions derived from this season's experience would be helpful in the future operation of this project, or helpful to others in planning and conducting the educational aspects of migrant health projects?

Many migrants have "home base" in Polk County. Their problems do not seem to be different from others on the same economic level except for language difficulties of the Spanish-speaking migrants in Gordonville, Eloise, Haines City, and some other areas. Schooling is a problem as many children do not come back with their families until late October when the citrus season begins. There is a need to educate parents to keep their children's immunizations up to date before they return for registration in day care centers and public schools. Migrants need to be educated to keep personal health records. They need to be motivated toward better health care for their families, not only for emergency situations, but for long range preventive health care as well.

SUMMARY

Except for an overproduction of citrus and periods of labor shortages, the agricultural migrant situation in Polk County remains the same as in previous report periods. Labor peaks have been somewhat prolonged and the harvest will be about one month longer than usual. This is due to the overproduction and a severe drought during March, April, and May. Early predictions are that the drought will reduce the size of next season's crop. The ethnicity of the agricultural migrant remains unchanged. No new or acceptable mechanical harvesters are predicted at this date, thus the need for harvest labor will remain approximately the same this year.

OBJECTIVES:

(1) To improve preventive and medical care services to agricultural migrant families.

(2) To improve and upgrade general sanitation and housing.

(3) To coordinate and cooperate with community agencies in assisting with programs for the betterment of agricultural migrants and their families.

A full range of public health services, including certain medical care services, is available to the agricultural migrant in the same way as it is to the resident population. All resident migrants have access to Polk General Hospital (county operated) for total medical care services according to established income eligibility. Non-resident migrants are cared for on an emergency basis. The health department holds general clinics in each of its nine district health centers. Services available in these clinics are physical examination, diagnosis, treatment, prenatal, pediatric, family planning, and dental services. Referral services for mental health, orthopedic, cancer, heart, rehabilitation, mental retardation, are available. Glaucoma detection is a special service. Tuberculosis is a serious medical problem in this group. The local Tuberculosis Association and the health department are planning an intensified field effort for early detection this fall.

Efforts to get the Polk County Medical Society to endorse a fee schedule as set up under the Migrant Project have failed. The Polk County Health Department obtained a new director on January 1, 1967, and the new director has had several very long discussions with the society to no avail. At the direction of the society in their deliberations of accepting a fee schedule, a survey of hospitals concerning their acceptance of migrants, recording occupational history, outpatient clinic services, and inpatient hospital care indicates a loss of $80,000.00 annually in Polk County. In another approach approval for the use of interns and residents in Family Service clinics has been obtained. We are hopeful that some improvement in service will come from continued work in the two above named approaches.

Sanitation services have been improved through cooperation and greater concern by local agencies. Although still substandard, much housing has been upgraded and maintained. Problems arise here in attitudes which are deeply ingrained - they don't know any better - if you give them something decent, they will tear it up, they like it this way. Trite maybe, but this is the way people think and act.

We are gradually improving and upgrading our total health program - adding services, revising methods of delivery, and reminding ourselves of the patient's need and planning accordingly.

Trapped by Years of Failure

By NORMA JEAN HILL
Ledger Staff Writer

Migrant laborers, long a matter of concern for state and federal officials, are perhaps finally going to have some measure of their plight alleviated. This series by The Ledger's Norma Jean Hill outlines the problems and what is being done to help solve them.

Trapped.

—living in a world, but not part of that world.

—birth, death, and nothing much in between.

roaming the face of this wealthy and "enlightened" country — more than 8,000 in Polk County schools — sometimes.

— And the ultimate pity of it is that they try — their parents work from dawn to dusk

SOCIETY HELPS MAKE THEM OUTCASTS

4-10-61

Migrants Dislike Their Plight

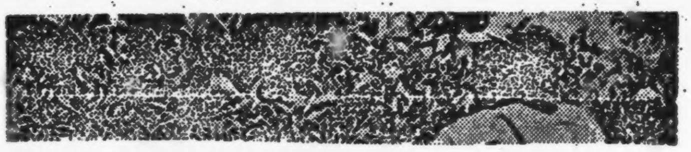
By NORMA JEAN HILL

Ledger Staff Writer

There is nothing basically wrong with migratory workers

either emotionally, culturally or mentally — for anything else.

Of course, as in every strata of society, there are those who just "don't care." There also



FEDERAL AID FOR EDUCATION

4-12-67

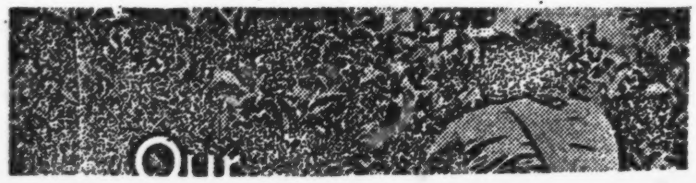
Migrants' Problems Get Action

By NORMA JEAN HILL
Ledger Staff Writer

Fourth of a Series

It has been said that migratory workers are like the

The money was released to the states by Washington last week, and the Florida State Department of Education says is ready to "go" with the program.



NOT ALWAYS EASY TO GIVE

4-11-67

Aid for Migrants Available

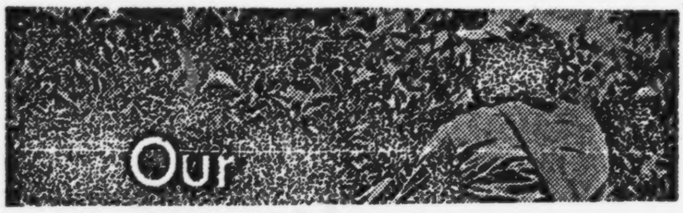
By NORMA JEAN HILL
Ledger Staff Writer

(Third of a Series)

There is help available in Polk County for the migratory worker and his family — educa-

are so ludicrous they almost become comic.

In a State Health Department report of 1965-'66, Polk County sanitarians reported difficulties in dealing with waste disposal problems in the groves.



Migrants: No Place Is Home

FROM 1-A

by living with the rawest facts of life almost from infancy,

among the workers and a sharp increase in Mexican-Americans.

Most school people say they enrolled more Mexican-American children this school year ..

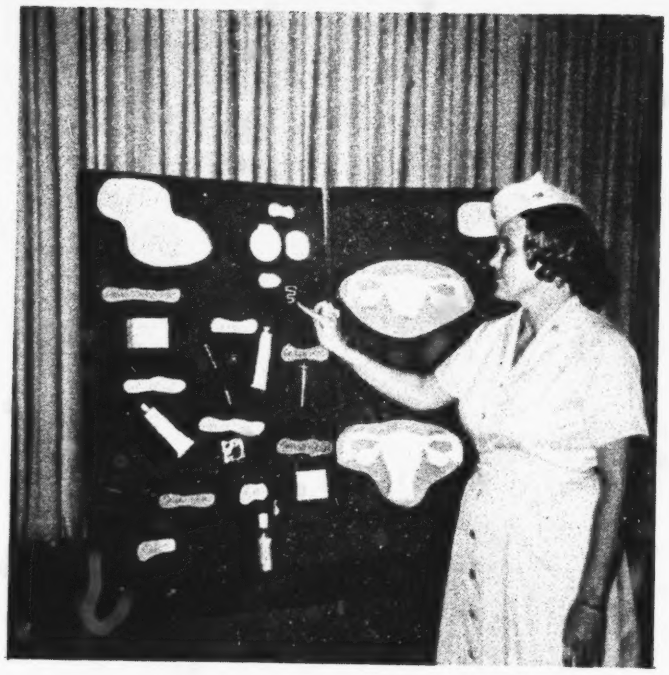
— are from the farms of other southern states.

— become migrants because they could not obtain other employment.

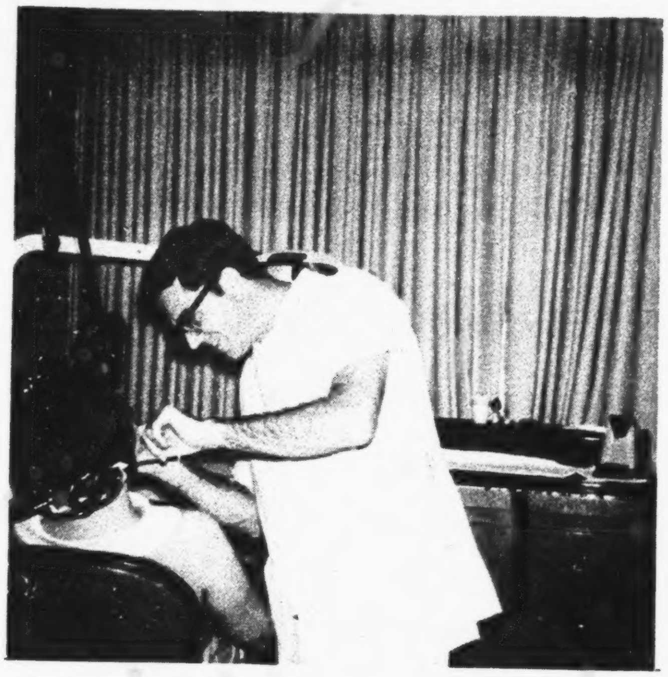
— have completed sixth grade.

— are "married" and have large families.

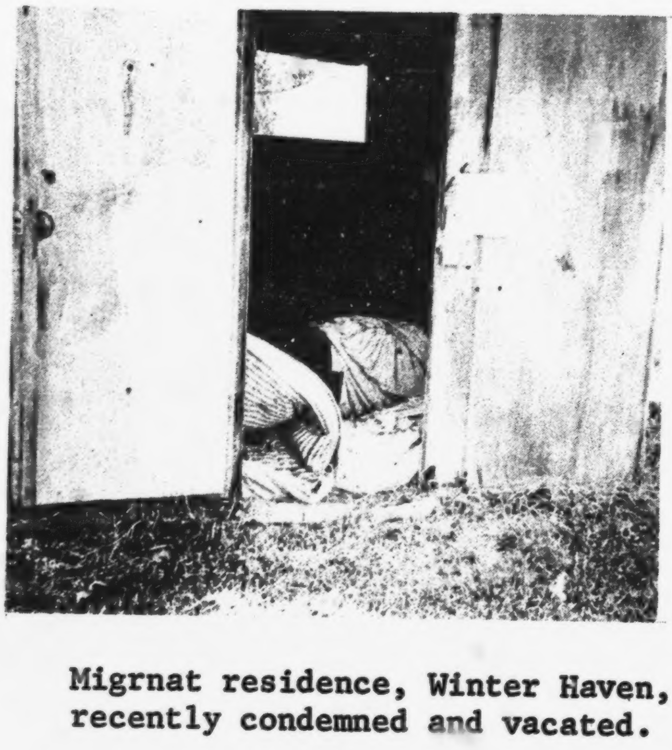
Newspaper clippings from "The Ledger", concerning Polk County migrants.



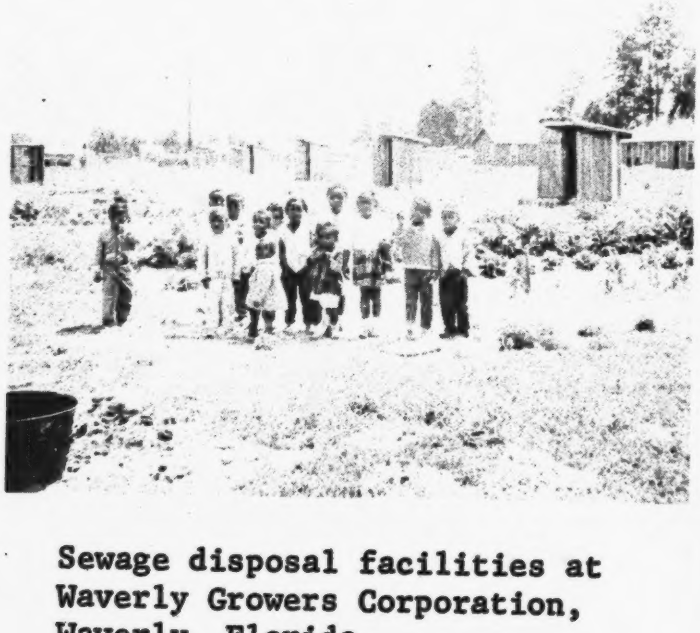
Shows recent Health Education display concerning Planned Parenthood.



Dentist giving services to expectant mother in Polk County.



Migrnat residence, Winter Haven, recently condemned and vacated.



Sewage disposal facilities at Waverly Growers Corporation, Waverly, Florida.

PUTNAM AND FLAGLER COUNTY HEALTH DEPARTMENTS

Julius C. Brooks, Jr., M. D., Director

Area of PUTNAM County: 803 square miles

Resident Population: 33,000

Number of Migrants: 3,000

Area of FLAGLER County: 483 square miles

Resident Population: 5,300

Number of Migrants: 800

MIGRANT PROJECT STAFF:
1 Public Health Nurse
1 Clerk-Typist
(Part-Time)

ANNUAL PROGRESS REPORT AND CONTINUATION REQUEST

COMPREHENSIVE HEALTH CARE FOR MIGRANT FARM WORKERS

PUTNAM AND FLAGLER COUNTIES

Introduction and Background Information

This is our second annual progress report covering the period from May 1, 1966, to April 30, 1967. Most of the migrant workers are not expected to leave the area until June, 1967, as the freeze in the latter part of February delayed the potato crop.

All budgeted positions are filled. A number of services have been offered, and we feel much good work has been done toward helping the migrant laborer and his family. The services offered have been sought out by these people and we feel they are greatly appreciated.

Domestic Agricultural Migrant Situation in Project Area

At the peak of the season an estimated 3,400 workers were employed. Growing conditions have been very favorable.

For a large number of our workers this is home base. Many maintain their residence here, leaving in May or June, and returning in October or November. Some own their homes; while others rent rooms, apartments, or houses for the period they are here. The majority of the non-resident workers come from Texas and southern Florida. On leaving this state they migrate to Alabama, Texas, Virginia, North Carolina, Michigan, Pennsylvania, New Jersey, or New York.

The majority of workers are Negro, with some Cubans and Mexicans. As a rule the Mexicans are here only a few weeks but this season many stayed for several months. They work mainly on the flower farms.

Family Health Service Clinics

Many migrants have been seen this season (1966-67) in the health department clinics. More would have been seen except that many times transportation to clinics was not available and also, in most instances, the laborer did not want to lose any time from work. Consequently, unless they urgently needed to see a physician, they did not attend clinics. Several of our local physicians saw patients referred by a public health nurse, and the physician was reimbursed on a fee-for-service basis.

Some of the different types of services offered by the health department include:

> Child Spacing, Venereal Disease, Tuberculosis, Maternal and Child Health, Immunization, Prenatal, Postnatal, Chest X-Ray, and Dental Care on an Emergency Basis.

Charts showing the number of patients seen in various clinics are included in a subsequent section.

The local physicians have been very cooperative in seeing migrants or their families, on a referral basis. Approximately 60 referrals have been made.

In our clinics we use individual teaching as much as time permits. In home visits and in the migrant camps good health habits are emphasized, by the nurses. Informative talks are made, literature distributed, and films shown. These are always well received. Films are also shown, in the Negro schools containing migrant pupils, and this practice will be continued during this year.

By talking with growers, camp managers, and crew leaders, we are striving to let them know that we are interested in improving existing living conditions, thereby improving the migrants' health.

Local church groups have offered assistance in the way of clothing for migrant families. The migrants are included in mission studies now, whereas a year or two ago this particular group was unknown. A great deal of interest has been aroused in the migrants as more becomes known regarding their living conditions, needs, and so forth. Still many people have little or no concern for those who make their living as the migrant does.

Forty health records were given to patients. Approximately 20 were presented in our clinics when migrants registered. Many told us they had been given health records but had lost them en route.

A good working relationship has been established with the employment agency. Again this year, when the Farm Labor Service Bureau Meeting was held for the purpose of employing migrant workers, a sanitarian attended. Talking with farm labor representatives from various states is an interesting experience.

Nursing Services in Camps or Other Places Where Migrants Live in Project Area

During the 1966-67 season, eight (8) public health nurses provided services for migrant workers and their families as a part of their generalized program. One nurse is employed full-time on the Project and the other seven spend a portion of their time on this program.

Home visits to migrants-----247

Migrant visits to clinics---350

All nurses in the migrant area are well-oriented as to the referral system. The major problem we have with the Interstate Referral System (which we feel has been very effective this year) is that many migrants leave the area without our knowledge. We are making plans to overcome this problem. By keeping in closer contact with crew leaders, we are hoping to have a greater number of referrals next year.

The migrants served in our clinics and the ones referred to local physicians seemed most appreciative.

This year there seemed to be a better working relationship between the crew leaders, laborers, and the health department staff. Many sought out our assistance and at no time were they demanding. There were a number of migrant laborers seen in the out-patient department, and in the emergency room. Fortunately, we did not have any seriously ill patients requiring in-patient hospital care.

We believe all migrants in the project area who had a medical need received care.

As yet we do not have in-service hospital care for migrants.

One hospital refused to participate in the inservice hospital programs, as the doctor does not receive fee-for-service according to the present setup. This hospital has reported a loss of $1,948.00 during this past season. Another hospital which has agreed to participate in the inservice hospital program reports a loss of $466.60. A premature baby was hospitalized in Shands Teaching Hospital, Gainesville, for a period of one month, at an approximate cost of $800.00. A tuberculosis patient was confined to the hospital in Tampa for four (4) months, at a cost of approximately $40.00 per day. We feel there is a definite need for the inservice hospital program.

The supervising Project nurse and part-time clerk typist attended a two-day Migrant Health Conference in Miami Beach in December, 1966. In July, 1966, the Project nurse attended a workshop conducted by Planned Parenthood Federation of America in Orlando. She also attended a regional conference on Child Spacing in Atlanta, Georgia in November, 1966. The Project nurse was a member of the instructional staff for the Agricultural Migrants and Family Planning Services Traineeship Program in Atlantic City, New Jersey in April, 1967. These meetings have proved most beneficial as new contacts were made and mutual problems were discussed.

Sanitation Services Related to Migrant Housing and Work Locations

There are no sanitarians employed by the Migrant Project. Of the four (4) full-time employed sanitarians, two (2) work part-time with the migrant project and are doing an excellent job. This work is performed in addition to their own numerous duties.

Laws for evaluating these camps are found in the:

(A) Sanitary Code of Florida, Chapter 170C-32 "Camps"

(B) Inspection Form, Camps SAN 435 (Rev. 8/60)

(C) Inspection Form, Food Service Establishment
SAN 413 (Rev. 7/63)

There are 18 camps in the project area; 15 family-type and 3 for males. The combined capacity of these camps is approximately 750 persons.

The following are sanitation services related to camps:

Inspection for permits - 23 visits.

Informal inspection to survey for proper construction, food service, water supply, sanitary facilities, sewage disposal, garbage and trash disposal, pest control, and general cleanliness - 80 visits.

Camps meeting existing standards - 13.

Camps meeting standards at end of season - 14.

Broken screens continue to be one of the major defects, as this tends to magnify the fly problem. Garbage disposal is a problem of several of the camps; while at others nearby livestock apparently provide fly breeding media. Other defects include improper trash disposal, health cards for kitchen workers, broken or inoperable toilets, showers and wash basins, toxic materials in the kitchens, and unkept grounds.

Defects are usually corrected soon after being pointed out. However, these corrections tend to be temporary. For instance: At one camp the screen door will be kicked out at top and bottom, or both within one week of repair. Garbage and trash can be cleaned up immediately but by the next day is piling up again.

There has been good cooperation from the camp owners in regard to corrections, but as previously pointed out, there is a need for more frequent inspections to insure more orderly camps.

Failure to permanently correct conditions is due to a combination of factors. Probably the most outstanding one is the tendency of the people to throw trash and anything they don't want right out the door and thus leaving an unsightly mess until a nurse or sanitarian comes along and starts a clean-up campaign. This is the responsibility of the camp manager, and it is here we must place emphasis on health education.

A large number of migrant families live in the municipalities and surrounding areas. A few homes are in good condition, some in fair condition, but most are barely habitable. Approximately 300 homes are in the latter category. There are a number of migrant workers who are single men and who melt into the local population, renting rooms in private homes or in cheap boarding houses. Some stay with local relatives or a girl friend. There are probably 350 in the latter category.

An undetermined number of migrants were reported to be staying in old houses in the Crescent City area. Estimated on the basis of complaints, 40 to 50 people have been involved.

Approximately 43 visits have been made to other than camp locations. Several visits were made in an effort to secure Farmers Home Administration financing for a new camp in the Federal Point area. This was turned down for lack of loan security. Several visits were made to a small non-permitted camp in Federal Point, which was finally condemned. Other visits were made because of complaints on garbage or trash disposal, or lack of toilet facilities.

There were six housing units meeting standards at the beginning of the season.

Three were brought up to standard, making a total of eight approved at the end of the season.

There were two units found with no water; and three without toilets. A water supply and a sewage disposal system were installed in one of the units and the other unit was condemned.

Failure to make corrections is here again due to a combination of factors:

(1) Lack of time for house-to-house inspection by sanitarians.

(2) Financial inability of owners to make improvements.

(3) Landlord reluctance to improve houses for various reasons.

(4) Many are satisfied with what they have.

(5) Hesitancy to condemn substandard housing while decent housing is in such short supply.

There were 12 field locations visited out of a total of approximately fifty locations. A total of 41 field visits were made.

Six locations had water supply for drinking and hand washing. Five with defects were corrected. Rules of the Florida State Board of Health are used in evaluating field sanitation.

The sanitarians have talked with camp managers regarding the necessity for better facilities and the proper care of these facilities. Crowded conditions, contagious diseases, and general sanitary conditions are the main themes of these talks. Migrants have a tendency to be apathetic and lazy, which combined with their general lack of education, requires a great deal of direction, guidance, counseling, and actual practical training in developing good personal habits. We feel that the camp managers and crew leaders are the ones who can do this most effectively.

A few individuals may be influenced by the doctor, nurse, or sanitarian, but the majority are never seen by health department personnel. However, this situation is gradually changing. With funds for travel, and increased interest in better housing (living conditions so to speak), the migrant is becoming more interested in bettering himself.

There were approximately 12 conferences with camp managers, crew leaders, and their wives giving counseling on specific problems; namely building new facilities, adding toilets and showers, inadequate drainfield, and failure of camp managers to report breakdowns in sewage systems to the proper authorities.

The following are working relationships:

Nurse - The migrant program revolves around the nurse. She meets a number of these people individually and each of these contacts may be most valuable. The nurse knows and has considerable influence with the camp managers, crew leaders, and their wives who are the key people in developing this program in the camps. The nurse is able to observe and report to the sanitarian conditions which need to be corrected and which otherwise would probably not be found.

The grower-nurse-sanitarian relationship is the backbone of the program.

Growers - These people are beginning to change some of their ideas. They seem to have a better understanding of the problems we face and are intelligent enough to know that any changes they make will, in the long run, benefit them.

Crew Leaders - A much better relationship has been developed between the nurse and crew leaders this year. They really are not too hard to sway - once they understand we need them as an important link in our program.

Employment Service - These people have a well-developed inter-state organization that could quite profitably adapt itself to this program.

The principle deterrent to housing and sanitation improvements is cost. Growers lose money some years and are not able to make repairs. There is also a feeling that if repairs are made they will be ignored, or torn up by some unappreciative and inconsiderate labor force. This contention has been largely well founded and only now are the attitudes of migrant workers beginning to change. This has been a long time process and involves all the rest of the program and the effort of all the people directing and cooperating in it. Other problems are trivial compared to this.

The migrants' acceptance of responsibility seems to be in a large measure improving. Through constant supervision and continuing education we are striving for this.

Community understanding has not improved too much. The people think of migrants as a necessary evil. This has developed from unfortunate experiences of the past. This year we have had few problems with respect to migrants getting in trouble with the law, etc. We fortunately have a good working relationship with the law enforcement staff. Several times this year we have been a real help in obtaining employment, resulting in migrants being released from jail, who were being held on minor charges.

Grower-migrant relationships are varied. Some deal entirely with the crew leader, others with the individual in a small group. It seems that when migrants leave Florida now they go to only one location, working for the same grower, year after year.

It is possible to keep pretty close surveillance over the camps, and central housing locations; but as mentioned before, so many live individually with the local population that they are practically impossible to locate.

Health Education Services

Needs for health education are gradually being met. The migrant has a reluctance to change from the way he has always lived. However, during the time the migrant project has been in our area, we have seen changes in living patterns being made.

The crew leaders and their wives have been most helpful in letting us know about illness of any of the workers. Also of other problems concerning the migrants that they feel we can be of assistance.

Other Items Pertinent to Future Project Development

During the coming season we would like to:

(1) Improve the general appearance of the migrant housing with assistance from the worker, crew leader, and owner.

(2) Encourage greater participation in our clinics.

(3) Be able to make more home and field visits to keep in closer contact with the needs of workers.

(4) Increase use of films in the schools.

(5) Conduct classes for migrants in a certain area pertaining to topics of interest to them.

(6) Continue on a larger scale mass T.B., V.D. and diabetic testing.

(7) Continue to strive for better understanding and working conditions of migrants.

PUBLIC HEALTH NURSING SERVICES FOR MIGRANTS

CLINIC AND HOME VISITS

SERVICE	TOTAL		May 1966		June 1966		July. 1966		Aug. 1966		Sept. 1966		Oct. 1966		Nov. 1966		Dec. 1966		Jan. 1967		Feb. 1967		Mar. 1967		April 1967	
	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H
Immunizations	41	3	5	3	3	0	1	0	0	0	0	0	0	0	2	0	8	0	7	0	5	0	5	0	5	0
Prenatal	78	11	10	5	12	1	2	0	1	0	0	0	4	0	6	0	8	4	9	0	8	0	9	0	9	1
Post Partum	12	14	5	3	3	1	1	0	1	0	0	0	0	0	0	2	1	0	0	1	0	1	1	1	0	5
Child Spacing	42	15	3	7	4	1	0	0	1	1	0	0	3	0	5	1	5	2	3	0	3	1	9	0	6	2
Chest X-Ray	8	30	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2	5	2	5	1	7	0	8	2	5
Tuberculosis	3	4	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0
Venereal Disease	12	10	0	0	0	0	0	0	0	0	1	0	0	0	4	0	0	1	3	5	0	0	1	3	3	1
Intest. Parasite	18	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	4	0	7	0	4	0	1	0	0	0
Diabetes	11	32	3	0	0	1	0	0	0	0	0	0	0	0	1	6	2	12	2	6	2	5	0	0	1	2
Injury	3	4	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	3	0	0
Dental	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
Morbidity	67	35	9	9	9	0	1	0	2	0	1	0	1	1	6	0	4	2	10	4	11	8	9	7	4	4
Health Appraisal	53	82	7	18	4	8	10	1	4	3	1	1	6	5	2	2	3	20	0	3	2	6	6	1	8	14
Mental Health	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	0	4	0	0	0	0	0	0
GRAND TOTAL	350	247																								

May 1, 1966 - April 30, 1967

PREVENTIVE SERVICES

May 1, 1966 - April 30, 1967

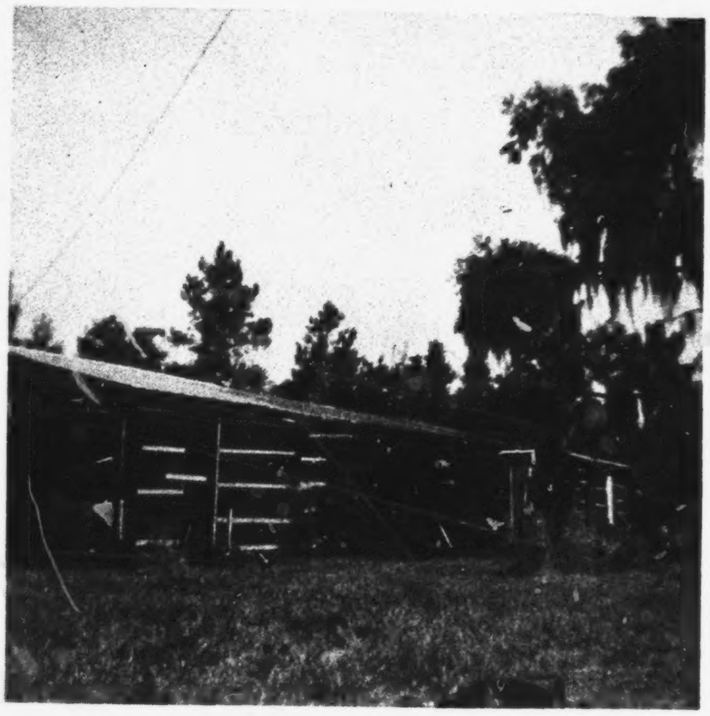
SERVICE	SEX AND AGE GROUPS									
	TOTAL		0-15		16-49		50 +		Unkn.	
	M	F	M	F	M	F	M	F	M	F
DPT	8	10	8	10						
DT		11				11				
POLIO	7	19	7	6		13				
SMALLPOX		1		1						
MEASLES										
CANCER CYTOLOGY										
CHEST X-RAY	5	2		1	4	1	1			
CHILD SPACING		28				26				2
HEALTH APPRAISAL	26	20	20	10	3	8	2		1	2
NUTRITION	1		1							
POST PARTUM		9		1		8				
PRENATAL		28				28				
MENTAL	3				1				2	
GRAND TOTAL	50	128								

CURATIVE SERVICES

May 1, 1966 - April 30, 1967

	SEX AND AGE GROUPS									
CONDITION OR PROBLEM	TOTAL		0-15		16-49		50 +		Unkn.	
	M	F	M	F	M	F	M	F	M	F
DIABETES	3	2				2	2		1	
INTEST. PARASITE	8	5	6	2					2	3
RHEUMATIC FEVER	1				1					
TUBERCULOSIS	5	1			4	1	1			
VENEREAL DISEASE	5	2			5	1				1
POISONING										
DENTAL	1	2			1	2				
INJURY	2	1			2	1				
CARDIAC										
EYE	1						1			
SKIN	9		2		5		2			
CRIPPLED CHILDREN										
OTHER (Morbidity)	41	24	13	5	16	15	7		5	4
GRAND TOTAL	76	37								

New camp in Flagler County,
good condition after one year.



Unapproved camp, Flagler County.

Buildings now in us, Putnam County.

Building now in use, will be
condemned. Flagler County.

SAINT LUCIE COUNTY HEALTH DEPARTMENT

Neill D. Miller, M. D., Director

Area of County:	601 square miles
Residnet Population:	39,294
Number of Migrants	10,000
Migrant Project Staff:	1 Public Health Nurse 1 Senior Sanitarian 1 Clerk-Typist (Part-Time)

DOMESTIC AGRICULTURAL MIGRANT SITUATION IN PROJECT AREA

ANNUAL PROGRESS REPORT

SAINT LUCIE COUNTY

Surveys of the migrant population have been conducted by the Sanitation staff from January through May of this year, 1967. The purpose of these surveys was to determine the number of migrant agricultural workers moving into the area. The surveys were made in the Lincoln Park section of Ft. Pierce, since most migrants seem to prefer to live in the city where there is activity rather than in the labor camps in isolated rural areas.

From January 1 to March 1 there were few migrants noted. The numbers increased very slowly but gradually. Work was limited as very little harvesting was going on and most of the available jobs were part-time in crop or grove cultivation.

On March 1 a population survey was made and the following information obtained: Drivers of 21 labor buses carrying migrants to either fruit or vegetable operations were interviewed. The early buses leaving between 4:00 a.m. and 5:30 a.m. and carrying 10 to 40 migrants were going to the vegetable fields for planting. About one-half of the buses were in this category. The other half were leaving for groves that were not in this immediate area, so had to leave early.

Activity in the Lincoln Park area was relatively light. Apparently the "season" is not at a peak at this time. The average estimated by the drivers ran from 10 to 40 with a mean of 26 workers per bus. The drivers heading for vegetables estimated between 30 and 40 workers per bus. The grove bus drivers estimated from 10 to 28 per bus. One bus was heading out with the driver and one worker. One bus was heading out to Port of Palm Beach with 17 stevedores.

The fruit pickers are apparently picked up individually with the Douglas Court loading zone being the focal point for laborers who are not on regular crews. At 4:00 a.m. there were six buses loading for vegetables at this point. At 7:00 - 7:20 a.m. there were seven buses in this area loading for fruit work. (The seven are not included in the 21 early interviews and expected to average 10 - 15 per bus for fruit picking.)

(Buses were leaving for areas near Homestead, Jupiter, Sneed Road, Jones, Fellsmere, Dade City, and Canaveral.)

Before 6:00 a.m. 46 labor buses were counted in the Lincoln Park area that were parked in various spots but were not loading. The seven late fruit buses were probably counted in with these.

The fruit company trucks were not in this survey. Ordinarily this type pick up at the workers' homes (probably full-time employees, 4 to 5 workers on small trucks - 10 to 15 men on large trucks). The trucks were not noticeable until about 6:30 a.m. or later, indicating work in local groves.

A close surveillance was maintained on the labor build-up to determine the peak period of migrants in the area. On May 1, it appeared that the peak of the season was at hand. A survey was conducted on the morning of May 2 in the same area or loading zone at Douglas Court. The following information was obtained: There were 40 buses loading between the hours of 4:00 a.m. and 7:30 a.m. Each bus averaged 40 workers with approximately half of the passengers being women. These women are local residents who each year work the picking season in the vegetable fields. The money they make supplements the family income and is always a welcome addition.

There were fifteen trucks loading in the zone, averaging ten workers each.

This group of workers was being transported to Indian River, Martin, Palm Beach, Okeechobee, Glades and Hendry counties, as well as working in St. Lucie County. A close check was maintained from May 1 for the remainder of the peak season which lasted five weeks, ending the first week in June. During this time it was observed that approximately the same number of workers were transported to the fields each day.

By the 10th of June the number of buses loading had been reduced to five, with approximately ten passengers each. The merchants in the area all agree, when questioned, that there appeared to be a mass exodus of workers about the first of June. The majority of workers were single males and were now moving to Georgia and South Carolina.

MIGRANT LABOR SURVEY IN LINCOLN PARK AREA

AREA

North Boundary - Avenue G

East Boundary - North 8th Street

South Boundary - Avenue C

West Boundary - North 12th Street

Total family units visited - 162 (excluding rooming houses)

Total inhabitants - 477

Actual agriculture workers - 140 - or - 29%

Family units with no agriculture workers - 74 - or - 46%

Family units with agriculture workers - 88 - or - 54%

Agriculture workers - 28 - or - 32% on vegetables
60 - or - 68% on citrus

Vegetable Season and Workers

Fall Season - September, October, November	) Depends on the weather, but this
Spring Season - March, April, May	) is normal.

Primarily women workers who average two to three days work a week and earn on the average of $9.00 per day.

These include women who are employed the year around in non-agriculture work, but quit their work during the "season" and pick vegetables. This group also includes the housewife who goes to the fields during the "season" and stays home the rest of the year. Her husband has year around employment but she wants to get away from the house or earn a few extra dollars for herself. This group will also include a few children who go to school during the week and work in the fields on weekends.

Citrus Season and Workers

Of the 162 units visited, a member(s) from 60 units is engaged in citrus. Thirty-eight are in year around employment, 22 in seasonal employment. The normal citrus season is from November to June. The majority of the citrus workers are men. Those who work year round average five to six days a week and earn on the average of $10.00 to $12.00 a day. (Very few of the year round citrus workers were willing to give their earnings.) The year around man usually has a family and their only income is from this work.

The man who only works in citrus during the season will work from five to seven days a week and earn on the average of $10.00 a day. This man may or may not have a family but will obtain other work during the off-season.

The above information does not include any figures from rooming houses. The owners and/or managers are only concerned with the rent. They do not know if their roomers work, how much they make, how long they will stay, and in many cases did not even know their names. Most rooms are rented by the week and with a high rate of turnover.

FAMILY HEALTH SERVICE CLINICS

The project staff will consist of one full-time public health nurse and one part-time clerk-typist II as of May, 1967. We plan to use Vista volunteers in the migrant clinic beginning with the next growing season.

The vast majority of migrants who will receive health service under this project grant do not live in labor camps but rather are absorbed in the general population in the lower socio-economic section of the city. A number are housed in the government low-cost housing project in this area.

Our first migrant clinic session is scheduled for Wednesday, June 7, 1967, from 6:30 p.m. to 9:30 p.m. at the facility located at 813 North 13th Street, Fort Pierce. Clinics at the health department, staffed by three public health nurses and the one migrant project nurse, are as follows: Prenatal Clinic every Tuesday and Thursday from 8:00 a.m. to 12:00 noon; X-ray clinic on Mondays from 9:00 a.m. to 11:30 a.m.; Planned Parenthood clinics twice a month 8:00 a.m. to 11:00 a.m.; General Immunization clinics every Friday 1:00 p.m. to 4:30 p.m.; Venereal Disease clinic on Fridays at 8:30 a.m. These clinics have been and still are available to the migrants.

Three children, two girls and one boy, under 15 years of age, were referred to the Florida Crippled Children's Commission - one for cardiac evaluation and treatment, and two for orthopedic service. Seven adult migrants were referred to migrant facilities in Virginia, Maryland, and New Jersey by means of the migrant referral system.

Health education efforts consisting of lectures to our prenatal and planned parenthood groups (usually numbering 25 to 30 patients per session) on all phases of basic family health are given. Our aims and purposes of the migrant clinic have been shared with the Vista volunteers. The newspapers have carried the message to the people.

Individual counseling has been given regarding specific methods relating to family planning.

Group counseling was provided before each prenatal clinic session. Problems relating to the prenatal and post-partum periods were discussed - including infant care and feeding problems. Demonstrations in formula preparation were given.

Talks given by nurses relating to basic health education, infant care, good nutrition, value of intestinal parasite control, family spacing, have contributed greatly in establishing communication with the migrants.

Groups with whom working relationships were established are as follows:

> The Adult Basic Education Program for migrants for the purpose of participating in the summer school sessions by means of a series of lectures given by the nurse.
>
> The Child Development Center for the purposes of providing immunizations of the children.
>
> The local pharmacists were contacted to inform them of the migrant program and also to ask their cooperation in the filling of prescriptions at Welfare rates or lower.

Crew leaders, Vista workers, Welfare directors of both county and state departments, Dean of Adult Education for migrants, CAO Committee, were contacted and the purpose and aims of the Migrant Project were explained. These groups will serve as a source of referral.

As a means of orientation, staff personnel (nurse, clerk and sanitarian) visited the Palm Beach County Health Department at which time they were included in one of their pre-clinic planning sessions where purposes and aims of the project were reviewed. We then observed one of their evening rural clinic sessions.

Migrant health status needs improvement. We do not render medical care in the health department. The people are referred to a private physician. We anticipate that the present burden that migrants put on the emergency room of the hospital will be reduced when we initiate our migrant clinic on North 13th Street, as the clinic will be rendering comprehensive medical care. We are hopeful that money will be included in our coming budget of 1968 for the payment of migrants' hospital bills, which will benefit the hospital, the migrant, and the paying patient who lives in the community.

It was not possible to serve all migrants. The necessary referrals were made to private physicians. This is a temporary arrangement until the migrant clinic opens and medical and dental services are available for the asking.

Health education needs were met as far as possible with available staff members under the existing plans and programs of the health department.

NURSING SERVICES IN CAMPS OR OTHER PLACES WHERE MIGRANTS LIVE IN PROJECT AREA

No project staff members were employed prior to May, 1967.

The number of conditions found requiring care is not available at this time as the health department records do not reflect this breakdown.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

A full-time sanitarian will be employed in the migrant program. Since none has been available to date, the only work performed was by the staff sanitarians of the health department. The labor camps are visited on a routine basis with housing facilities, water supply, garbage disposal,and sewage systems being inspected. In the Lincoln Park area of Ft. Pierce,where the majority of migrants live, housing, food service facilities, garbage and trash disposal; and sewage disposal facilities are investigated or inspected on a regular basis by the sanitarians.

The City of Ft. Pierce has adopted a minimum housing code which has been, and will continue to be, a great aid in eliminating substandard housing.

Available information indicates that there are a negligible number of migrants living in the labor camps. One camp that made elaborate preparations last year to house single males, found that they could not afford to keep the facilities open this year. The dormitory opened at the beginning of the citrus harvesting season but soon closed since the men preferred to live in town where they could join in the night life.

One large citrus company is considering building housing facilities for laborers but are debating whether to build it at the grove where they (the owners) prefer, or near town where the laborers prefer. No doubt if the facilities are to be utilized, they must be built near the center of population.

During the past few months, several apartment buildings have been built by citrus interests to house migrant labor. In each instance, these facilities have been built in the Lincoln Park area convenient to the center of activity.

The number of labor camps at the citrus groves appears to be static since no new ones have been built within the last 12 months.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

We now have adequate facilities comprising waiting room area, nurse's office, clinic area, dental area with dark room and storage space.

We have not been able to hire a sanitarian due to the shortage of personnel in that discipline. Continued effort will be made to acquire a sanitarian.

We experienced some difficulty in finding the above-mentioned facilities and in the renovation of said facility.

The starting date was changed from January 1, 1967 to March 1, 1967 at the direction of the U. S. Public Health Service.

PROJECT OBJECTIVES

Since our Migrant Clinic has practically reached reality, our objectives are substantially the same as outlined in our original application. Following many delays and problems, our first clinic session will be held June 6, 1967. The need for this service has been established. Our objectives to serve these needs are as follows:

(1) To make comprehensive medical care available to the migrant population.

(2) To make dental service, primarily emergency care, available to the migrant population.

(3) To increase nursing services to the migrant population.

(4) To upgrade the environmental health conditions of the migrant population.

OBJECTIVE #1

Our clinic space has been leased at 813 North 13th Street. Physicians have agreed to operate night clinics. A full-time public health nurse and a part-time clerk-typist II will soon be employed to carry on the program. Clinics will be held more often in the fall when the target population returns to this area. Afternoon clinic sessions are planned when the number of migrant families needing services indicates this is desirable. The public health nurse will devote a large amount of her time, when not in clinic sessions, to field work making the migrant families aware of the services available.

OBJECTIVE #2

Dental equipment has been secured and is in the process of being repaired for installation. A dentist has agreed to serve as clinician for the clinic. A dark room will also be set up for his use. Referrals will be authorized when necessary by the clinician, when the service requires a specialist. Dentures will not be provided, only work of an emergency nature will be done. Fee-for-service schedules for both physicians and dentists will be identical with that of other project counties; i.e., $4.00 for the first visit and $3.00 for each additional visit for the same ailment. Surgical procedures will be charged at 60% of Blue Shield Schedule "A" Plan. Minimum charges will be made for necessary laboratory work performed on patients. Prescriptions for migrant patients which are filled by pharmacists will be charged to the project at the State Public Assistance rate. Medication will also be dispensed by the project clinicians.

OBJECTIVE #3

The full-time public health nurse about to be employed for the Migrant Project will assist the clinicians, make home visits, do follow-ups on patients, make referrals and necessary investigations for eligibility in connection with referrals, made inter/intra-state referrals to assure health service continuity, etc. She will also carry on health education activities with the migrant adults and children.

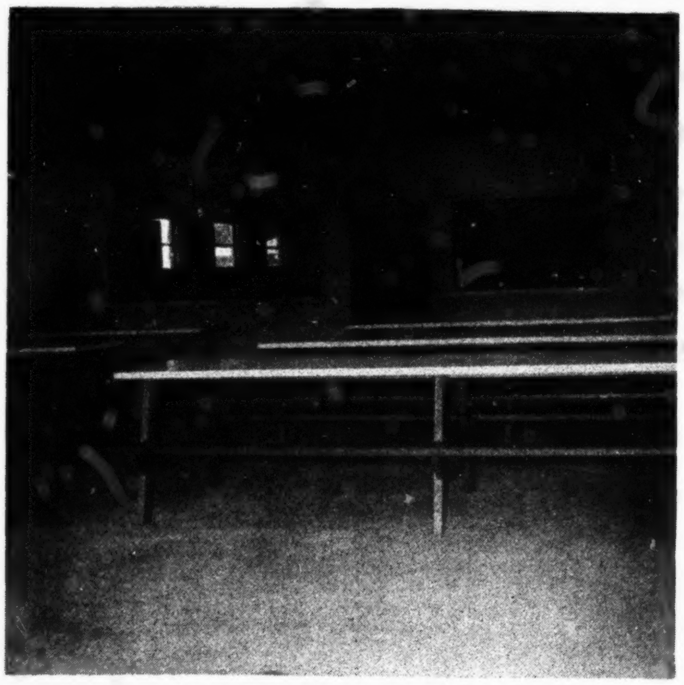
OBJECTIVE #4

It has been impossible to recruit a senior sanitarian to date. It is hoped that this position can be filled shortly. There is an urgent need to improve the existing environmental conditions under which the migrants live. It is the intent of the health director that a well-rounded and complete health education program be carried on. His tools would be the printed word, talks and audio-visual aids. This would involve working with migrants, landlords, officials, camp operators and the general public to improve housing, sanitary facilities, etc. Rodent control is of vital importance to the health and well-being of the target population. The sanitarian would also work with the public health nurse in investigative procedures.

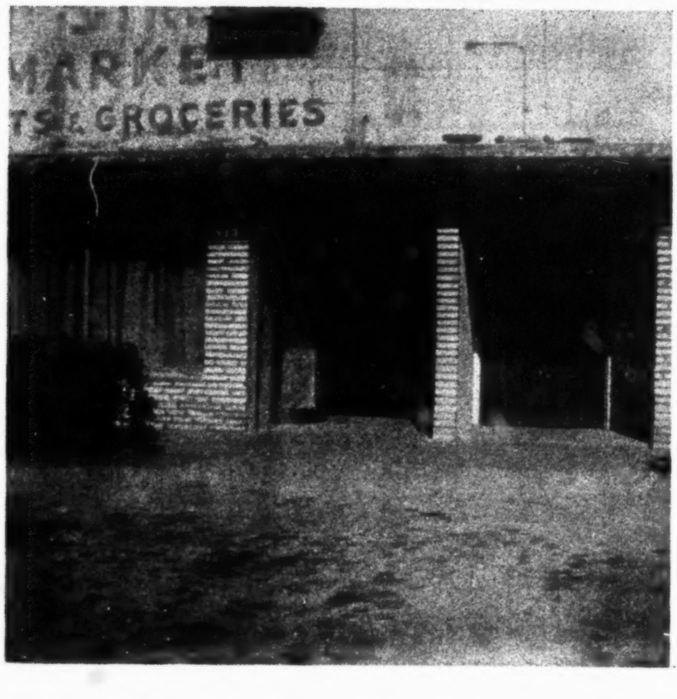
SUMMARY

While our health service program for the migrant population has gotten off to a slow start because of many difficulties, it is felt that a sound program is now under implementation and we look forward with a positive anticipation to a steadily improved and more comprehensive program. The groundwork has been laid; services should expand now as rapidly as feasible in order to fulfill the medical needs of the migrant and his family.

Migrant rooming house, Fort Pierce.



Dining area, DiGiorgio Labor Camp. St. Lucie County.


MARKET
GROCERIES

Migrant Health Clinic.
Fort Pierce.

SARASOTA COUNTY HEALTH DEPARTMENT

David L. Crane, M. D., Director

Area of County: 586 square miles

Resident Population: 95,000

Number of Migrants: 2,000

Migrant Project Staff: 1 Public Health Nurse
1 Sanitarian
1 Clerk-Typist
(Part-Time)

SARASOTA COUNTY HEALTH DEPARTMENT

MIGRANT PROJECT ANNUAL PROGRESS REPORT

May 1, 1966 - April 30, 1967

INTRODUCTION:

In order to obtain some perspective, as to developments in the Sarasota Project, one must review the activities of this season since the return of the majority of our migrants starts each year in October.

As a result of our review of the program of the preceeding year, it was obvious that we had not provided adequate medical care to the migrant in our community. While staff members did their best to locate and refer migrant workers, and their dependents, to local physicians and dentists for care, it became obvious that the paucity of transportation available, the distances involved and the unfamiliarity of the isolated migrant with the community, resulted in a breakdown in bringing migrant and professional together under circumstances conducive to the provision of effective Medical and Dental services.

Therefore, the staff determined early in the season that we would provide a family health service clinic in the vicinity of the camp area, if any facility could be found and utilized for this purpose. The project sanitarian was given the task of finding such a facility and succeeded far beyond our fondest dreams. He located 2,400 square feet of vacant space on the second floor of a sturdy building and obtained agreement of the owners to permit its use the first year free of charge - provided the facility would be redecorated at no cost to the owners.

With little more than faith, a lease was signed and we were in possession of space - in terrible condition - but space none-the-less, only about one mile from the major migrant camp areas. Knowing of the past interest of the local United Church Women, the team appealed to this group for assistance to put the facility in condition for clinic operation to begin. During November furious and heroic work was done by volunteers too numerous to mention, but spearheaded by the Pastor and members of the Trinity Methodist Church. Monday evening, December 5, 1966 at 5:30 p.m., the FAME Center (Fruitville Area Medical and Educational Center) opened to receive the first patient. An effective, convenient, evening medical service program was finally underway in Sarasota County!

From the outset we have adopted the principle that the project, like any other health service endeavor, was a team-work effort. Each member brought to the team his or her special skills and these, when melded, formed the framework through which service was rendered. Operational policies, methodology and mutual support for specific activities were gained by each team member being fully aware of his role as a portion of the whole, as well as his responsibility to contribute that segment of the team effort which fell in his area of expertise. While each team member ministered to the bodily needs of each patient, each did so in his own way, utilizing his own experience as a basis for advice and service. In this manner an amalgamation of the best ideas can be brought to bear on a given problem.

The team consisted of the Medical Director, Public Health Nurse, Environmental Health Specialist and the Administrative Services representative. Each was invoked in program planning, field implementation and in providing service at the family health clinics. Due to the size and complexities of clinics, non-project, health department staff were utilized on a voluntary basis to assist, as were interested citizens from the community. Team members were also taught simple duties, not part of their usual routine, to assist in handling the clinic load. EXAMPLE: Environmental Health Specialist performed hemoglobin, dextro-stix tests, weighed patients, provided information on birth control methods to husbands who were reluctant to discuss their attitudes with the nurses. In this fashion, comprehensive health service to the entire family was available in the clinic, as well as the field.

PROJECT OBJECTIVES:

Let us look at Project Objectives to see how we measured up.

(1) To continue to provide opportunities for State and Local Public Health Officials and others to evaluate the program for migrants and to plan for its improvement. Substantially Achieved. The Health Department and the Community did evaluate our program - it was found wanting and was improved to the fullest extent possible within the scope of available funds, personnel and facilities.

(2) To implement the basic service program on a state-wide basis. Substantially Achieved. So far as Sarasota County is concerned, the basic service program has been established.

(3) Pamphlets - This was entirely a State Objective. However, we have utilized the materials produced by the state in our program and feel they have been useful in assisting migrants, particularly the Spanish speaking groups to better understand their health needs.

(4) To offer comprehensive medical treatment, except hospitalization, in selected counties. Substantially Achieved. We have been able to provide virtually every necessary medical treatment or service required by our migrants and their dependents. These have included physical examination, diagnosis of disease and indicated treatment, obstetric and/or surgical care, preventive service, laboratory tests, Radiologic examinations, dental evaluation and treatment, emergency care for accidents or injury, hospital inpatient care when required and rehabilitation services. Many of these services were provided free of cost to the patient and the project, through community resources or the charity of local physicians.

(5) To offer specified types of dental services to migrants in selected counties. Substantially Achieved. Dental examinations and referral for major dental service of an urgent nature has been provided to all migrants who were evaluated in the clinic program.

(6) To help solve the Migrant's Transportation problems. Substantially Achieved. First and most important, the Migrant Clinic was brought to the Migrant Camp area so that migrants could conveniently take advantage of the services available. In addition all cases referred to other resources for service were followed-up by the nurses and wherever necessary transportation was arranged via volunteers or by paying a small service fee to a neighbor or

friend to get the migrant to the service. In many cases the Crew Leader or grower provided transportation at no charge to assure that the migrant was cared for.

(7) To revise and make use of the referral system, if it is found to be useful. Substantially Achieved. We feel this system has proven itself as an effective tool on the East Coast. We have assisted in certain revising of the form and we have been utilizing it to assure continuity of medical care and follow-up for all of our migrants who need this service.

OTHER OBJECTIVES ADDED: 1966 - 1967 SEASON.

(1) To continue to improve the environmental health aspects of the migrants existance. Substantially Achieved. Three of our four existing camps have been approved and permitted this year. Water supplies are adequate, the camp facilities were improved, garbage collection provided and at one camp a part-time camp manager hired by the grower to assure cleanliness and protection of the property as well as the migrant.

The single deplorable camp which contained 67 shacks last year has passed through two major clean-up sessions including burn-off and burying of debris, etc. The camp has been reduced to only about 31 of the better cabins. The Environmental Health Specialist has worked diligently toward a Farmer's Home Loan program for migrants. The first three homes will be constructed this year, after complex rezoning matters were cleared through the County Commissioners and other County officials. Expansion of this program will permit the final clean-up of this bad camp and new homes for many migrants.

So much time and effort has been spent on these matters that little progress has been made toward field sanitary facilities. We had to set priorities on a first-things-first basis. We did so and the field sanitary facilities were pushed to the rear this year.

(2) To develop, utilize and revise when advisable, a uniform system of forms and records for all project counties. Partially Achieved. Members of our staff served on the Records Review Committee and we are now utilizing the same record system as other project counties. The records seem to fit our needs adequately so that no revision has occurred, to date.

(3) To test a procedure for extending Health Education to migrants and compiling information on the migrant population through the use of liaison workers. Not attempted to date. Next season we do plan to hire a VISTA worker, who speaks spanish, as a Sanitarian Aide. While he is not of the Migrant peer group, he has worked with our migrants for two years and has a very close relationship with the migrants. Thus he will serve essentially the same purpose; to extend our service and general health education into the homes of our migrant families.

(4) To continue to inform the general public and certain groups of the projects aims and the migrant's problems. Substantially Achieved. In order to obtain volunteer assistance, funds, equipment, etc. to operate our clinic program, we made a broader effort to inform the community about the migrant, his family, and his needs. As a result the community has adopted the Migrant Project and is pitching in to assist in every way possible.

PROBLEMS ENCOUNTERED:

Whether integration into the community can be considered as a problem or not, we are not sure. However, to the extent that it makes it more difficult to locate the needy migrant families, it is a problem. This has occurred more extensively this year. Part of this is due to the reduction of housing in the camp area. During the past year more than 35 substandard dwellings were bulldozed out and burned in the very bad Johnson Camp area. Obviously the migrants who had occupied these quarters in former years had to move into town. Most found houses in the Newtown (Negro housing) area of Sarasota. Thus dispersed they were more difficult to locate. We did find that once the clinic was opened they made it a point to find us, on Monday evenings, for medical care. It seems that an effective service program will draw from areas separated from the migrant's camps if the people are sufficiently motivated to attend and feel they are being well served. We had quite a few patients who came from Manatee County, a trip of over 10 miles, to attend our clinic.

We still have made a very little impression on the general attitude of the County Medical Society. While a number of individual physicians have agreed to work in our clinic program next season (several have volunteered to work free of charge), the society's position is still in opposition to out-patient clinic services. They maintain that any needy patient may receive care, free of charge if required, at their private office during regular hours so there is no real need for a night clinic in the migrant area.

The Sarasota Memorial Hospital Board voted not to participate in the In-hospital service coverage available under the amended Migrant Health Service Act. They stated their reason for this stand was that the four surrounding counties, contiguous to Sarasota County, were not eligible for the in-hospital service program and thus acceptance of this program in Sarasota would open the hospital to serve migrants from surrounding counties where hospital service was not made available. They felt they could not risk filling hospital beds with migrants from surrounding areas while Sarasota County people could not get a bed. The Migrant Season parallels our Tourist season, so that hospital space is at a premium in December, January, February and March. Thus the hospital Board was, we believe, being realistic in this decision. To date, no migrant who has really required hospital admission has been refused admission, to the best of our knowledge. Thus we count this as a community contribution toward our Migrant Health Service Program. We are not able to clearly identify the magnitude of this contribution since the hospital has not, to date, separated migrants from other charity cases so that we could fix a dollar cost to this item. We have been able to identify about $2,500.00 worth of such care from patients we personally referred to the hospital. We believe contributed care by physicians and hospital would total at least $5,000.00 were we able to substantiate all service provided.

FAME CLINIC

The Migrant team decided near the end of October, that a family health service clinic was a necessity if we were to improve the quality of Medical care for Migrants in Sarasota County. The team envisioned this clinic as part of a center that would become the hub of our busy migrant area, a sort of "Home away from Home."

The community support was overwhelming, as church groups and individuals pitched in to help rebuild our old building. Four clinic rooms were rebuilt and furnished and Fruitville Area Medical and Educational Center (FAME Center) became a reality.

Enthusiasm - The word that has sparked this endeavor from the beginning - led us to hold our first Migrant Medical Clinic on Monday night, December 5, 1966 before the building was even finished. The fact that we had no running water didn't stop us from holding an unbelievably successful clinic, with 46 patients attending. It has been a rare clinic that cared for less than 25 patients and our average attendance has been over 30 patients.

With the cooperation of the crew leaders and growers, most of the migrant workers entering Sarasota County were brought to the clinic and given a thorough health screening before starting to work in the fields. Each patient was given a physical examination, STS, hemoglobin test, blood sugar test (dextrostix), necessary immunizations and was begun on medications if such were needed. In addition a social history was obtained on most. The staff consisted of the Public Health Nurse, Sanitarian and Clerk assigned to the Project, plus volunteers including one to three additional nurses, staff social worker, staff V.D. investigator, translators, VISTA worker and the Director of the Sarasota County Health Department who served as clinic physician at each clinic except one, when he was attending a Washington meeting. That clinic was staffed by a community physician who agreed to assist in the Director's absence. Acute, serious or complex cases were referred to local doctors or dentists for care too complicated for the clinic to provide (surgery, control of diabetes, etc.). Each case was followed-up by the project nurse to assure that the patient did get the required service. In most cases volunteers were necessary to provide transportation and assure that the patient did get to the source of attention.

Two clinics were held in December, two in January, four in February, four in March, and two in April. In these fourteen clinic sessions over four hundred-fifty patients were served; of these there were three-hundred-nineteen different patients given examination and treatment, if such was indicated.

Prior to the clinic sessions, much groundwork was done by our nurse, clerk and sanitarian working together and making visits to the growers, to the workers in the fields and to the crew leaders. Surely, much of the success of the clinic was due to this teamwork.

FAME CLINIC

December 5, 1966 - April 17, 1967

TABLE I

MONTH	NUMBER OF CLINICS	NUMBER OF PATIENTS PER MONTH
December	2	65
January	2	91
February	4	109
March	4	134
April	2	52
TOTAL	14	451

AVERAGE NUMBER OF PATIENTS PER CLINIC	32
NEW PATIENT VISITS	319
OLD PATIENT VISITS	132

PATIENT RETURN - 52%

MIGRANTS TREATED AT CLINIC

TABLE II

AGE	NEGRO		MEXICAN		ANGLO	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
	104	154	73	71	21	28
TOTAL	258		144		49	
0 - 1	2	5	2	6	1	1
1 - 4	10	5	1	6	1	0
5 - 15	8	21	9	9	3	8
15 - 44	44	75	55	45	7	14
45 +	40	48	6	5	9	5

GENERAL MEDICAL EXAMINATIONS - 319

FAME CLINIC

TABLE III

TOTAL NUMBER OF HOURS WORKED AT CLINIC

MIGRANT PERSONNEL:	**HOURS**:
Public Health Nurse	65
Sanitarian	65
Clerk	70
HEALTH DEPARTMENT PERSONNEL:	
Health Officer	65
Assistant Nursing Director	50
Public Health Nurses	100
V. D. Investigator	30
Social Worker	12
VOLUNTEER HELP:	
VISTA Worker	65
Interpreter	70
Doctor	4
Nurses	150
TOTAL	746

FAME CLINIC

TABLE IV

MEDICAL STATISTICS:

CONDITION	AGE 0 - 1	1 - 4	5 - 15	15 - 44	45 +	SEX Male	Female	ETHNIC GROUP Negro	Mexican	Anglo	TOTAL
Allergy					2	2		2			2
Arthritis				2	6	6	2	8			8
C.V.D.			2	25	54	42	39	59	18	4	81
Child Spacing				6			6	2	4		6
Dental			3	12	6	7	14	15	5	1	21
Diabetes					7		7	7			7
E.N.T.		3	5	6	1	4	11	8	5	2	15
Eye				5	3	4	4	5	3		8
G.I.			1	12	3	7	9	4	10	2	16
G.U.			1		3	1	3	3	1		4
GYN.				7	1		8	6	2		8
Immunizations		2	9	57	5	37	36	49	20	4	73
Int. Parasites		2	2			1	3	3		1	4
Maternity				6	1		7	5	2		7
Neuro				5	3	2	6	4	4		8
Neg. Findings	2	1		54	5	27	35	36	13	13	62
Orthopedic			1	9	2	7	5	5	6	1	12
Psychiatry				1	1		2	2			2
Skin	2	6	6	9		13	10	12	10	1	23
Surg. Proc.			2	1			3	1	2		3
Trauma Accid.				1	1	2				2	2
T.B.		1		4			5	5			5
Tumor				2	1	2	1	1	2		3
U.R.I.	10	7	6	12	6	22	19	16	17	8	41
V.D.				7		4	3	6	1		7
Other	1			4			5	2	2	1	5
	15	22	38	247	111	190	243	266	127	40	433

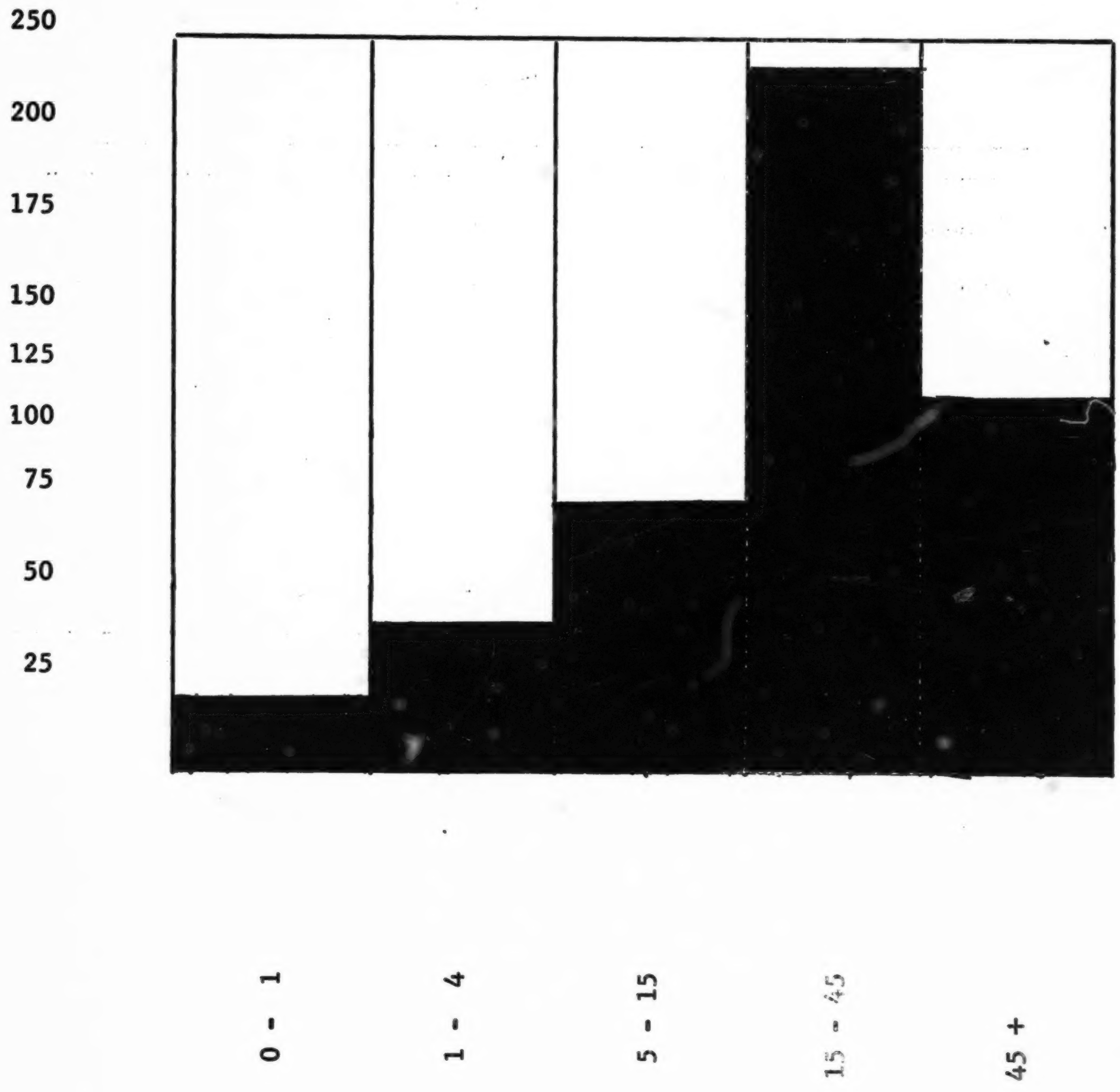
FAME CLINIC

TABLE V

CLINIC LABORATORY WORK

TYPE	NUMBER
Hemoglobin	185
V.D.R.L.	170
Dextrostix	180
Urinalysis	3

MIGRANT CLINIC AGE SCALE

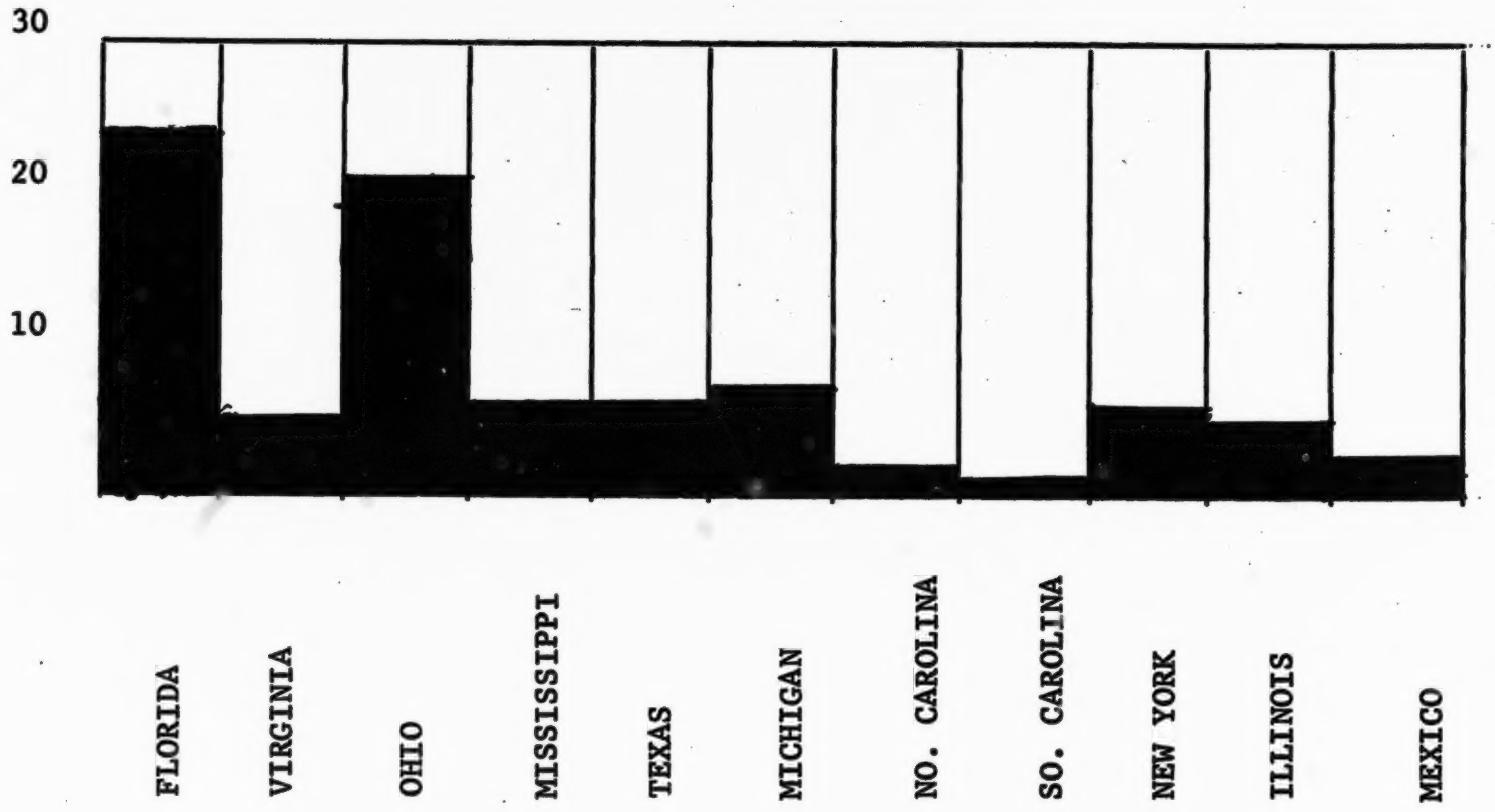


DENTAL HEALTH

TABLE I

	1 - 4	5 - 17	18 & OVER
Dental Inspections	-	13	4
Number Requiring Treatment	-	2	-
Fillings	-	27	-
Extractions	-	31	19
X-rays	-	21	3
Prophylaxis & Fluoride	-	3	-
Referrals	-	14	7

AREAS TO WHICH HEALTH REFERRALS WERE INITIATED



REFERRALS

Initiated from Sarasota, Florida:

Number of referrals initiated		81
Number of referrals completed	9	
Number of referrals incomplete	9	
Services not provided	8	
Public Health Nurse sought out	11	
Unable to locate	3	
No return on referrals	41	

CLINIC REFERRALS

Private doctor	23
Private Dentist	36
X-ray's (14 x 17) Health Department	40
Tumor clinic	1
Health Department clinic	102

U. S. Public Health Service Cards Issued................................ 75

NURSING

The nursing services described in the previous year's report were largely educational in nature. The public health nurse became acquainted with the migrants, determined their major problems and needs, and started various educational activities. Classes in general hygiene, infant care, social adjustment, and child care were begun. Efforts were made to educate the growers and camp owners as to the health needs of their migrants.

The extensive groundwork laid last year, greatly increased the effectiveness of the nursing program this year. One full-time public health nurse, employed by the Migrant Project, made regular visits to all four migrant camp areas every day and frequently also made evening visits. When the day care center opened, daily visits were made by the nurses. When large concentrations of migrants were found to be living in urban areas, the nurse also made regular visits to these districts. These people knew that the nurse would make daily rounds, and they came to her with all their health problems and questions. She was welcomed into their homes and looked up to as a friend and helper.

The nurse was assisted in determining health needs by many capable volunteers. A VISTA worker who spoke spanish was most helpful to her in working with the Mexican groups. Church groups and volunteers also visited frequently in the camp areas.

Transportation to doctors offices, etc. had been a major problem in the past, but the nurse encouraged volunteers to form an effective transportation corps. In this way, the nurse was assured that appointments would be kept, and private physicians were pleased that patients arrived at the right time and place.

Local physicians also expressed much more interest in treating our patients when they were informed of our use of referral forms for follow-up care of patients when they left the area. Their attitude had been, "Why bother to initiate treatment or immunizations when they'll be here today and gone tomorrow." When the doctors realized that continuity of care was possible through the use of our Migrant Health Referral Forms, they were much more receptive to the idea of treating our patients.

The opening of our Family Health Service Clinic on Monday evenings brought many more follow-up visits for our nurse. (See Nursing, Table III)

After each clinic session, home visits were being made to see that doctor's orders were being carried out properly. Also after each clinic, tuberculin skin tests were read - usually in the fields or at home in the evenings. In this effort, two or three other public health nurses, not paid by Project funds, assisted. Other public health nurses volunteered for evening clinic duty. (See FAME CLINIC, Table III)

All new nurses on our Health Department staff spent one evening session at the clinic as an orientation to the various laboratory tests and procedures that they would be doing as public health nurses. This helped in staffing the clinic and also served as an effective tool for inservice education for our new nurses.

While as many patients as possible were treated and given medications during our weekly clinic sessions, many patients were referred to private physicians, dentists, laboratories, or other agencies. (See NURSING, Clinic Referrals). The nurse made these referrals, made appointments, and arranged for transportation for these patients. Whenever possible crew leaders were involved and encouraged to make arrangements for these referrals.

Working through growers and crew leaders proved to be especially effective in our special evening x-ray clinic. While some patients were given x-rays during our regular afternoon clinics at the health department, it was necessary to schedule an extra evening clinic for migrants with positive skin tests. Lists were sent to growers and crew leaders and 33 out of 35 patients came to this x-ray clinic. (The other 2 had gone north).

Regular monthly immunization clinics were also held on Tuesday evenings and immunizations among most of the migrant children in our area are now at a high level (See NURSING, Table I). Well Baby Clinics were held monthly, with a VISTA doctor from Manatee County assisting, until our Family Health Service Clinic was opened.

Twenty of our migrant patients were referred to Maternity Clinic at our local hospital. This clinic is conducted by local private physicians and public health nurses and provides complete examinations, laboratory work, and medication for these patients. Transportation was arranged for all of their Maternity Clinic appointments and in most cases a translator was also necessary. After delivery these patients were given help in family planning. (This advice was also given to patients at the Family Service Clinic.)

Our nurse gave many talks before various community, civic and church groups to explain the plight of the migrant and to interest them in helping with our project. We would like to present a case study to one family to show the great extent of community involvement and support. CASE STUDY: One of our Mexican families arrived in our county in dire need of medical care. Though they spoke no English at all, our nurse observed the withered leg of the sixteen month old baby and referred him to Florida Crippled Children's Commission with a tentative diagnosis of post-polio. A Professor from New College accompanied the family to clinic and translated a history of probable polio last spring in Mexico. Because of this history doctors at Crippled Children's Clinic requested that we give polio vaccine to all Mexican Migrants in our area. We were able to do this also, through our Migrant Clinic. The child was then referred to Happiness House, where he receives physical therapy three times a week. Community volunteers transport the child back and forth for us. Without this kind of community support shown in this case study, our clinic and our program could not have been the great success that it was this year.

We mentioned as a problem in our nursing report for last year, the reluctance of these patients to seek medical assistance. After the gratifying turnout at all of our clinic sessions, their willingness to keep appointments, and their interest in reporting complaints to the nurse, we can surely say that this problem has been solved this year! An effective nursing service was provided for our migrants and even more important - it was used by them.

NURSING

TABLE I

IMMUNIZATIONS COMPLETED

TYPE	0 - 1	1 - 4	5 - Over	Booster
Smallpox		17	1	
Diptheria	4	19	6	35
Pertussis	4	11	4	10
Tetanus	3	6	44	24
Oral Polio	5	15	6	8
Typhoid		4		
Measles	4			

NOTE: This table shows completed immunizations only. All patients were started on immunizations and referrals were sent for completion of the basic series.

NURSING

TABLE II

REFERRALS BY PUBLIC HEALTH NURSE

REFERRED TO:	NUMBER:
Emergency Room	35
Private Physician	50
Private Dentists	15

NURSING

TABLE III

COMMUNICABLE DISEASE:

TYPE:	NUMBER:
Parasites Treated	28
V.D. Diagnosis	36
V.D. Field Visits	28

TUBERCULOSIS:

Active	Quiescent	Inactive	Contact	Tests T.B.	X-ray's T.B.
2	1	1	3	152	35

MATERNITY:

TYPE:	NUMBER:
Admitted to Service	20
Field Visits	96
Child Spacing	14

CHILD HEALTH:

TYPE	0 - 1	1 - 4	5 - OVER	NEW BABY COURTESY VISITS
Admissions	38	58	50	
Visits	107	81	114	6

MENTAL HEALTH:

TYPE:	NUMBER:
Admissions to Service	3
State Hospital	0
Visits	7

CHRONIC DISEASE:

TYPE:	NUMBER:	TYPE:	NUMBER:
Cervical Cytology	1	Cancer Admissions	3
Diabeste Admissions	5	Cancer Visits	32
Diabetes Visits	11	Other Admissions	33
Relatives/others Tested	180	Other Visits	175
New Cases	3		

ENVIRONMENTAL HEALTH

While migrant camps are permitted in accordance with Chapter 170C-32 of the Florida State Sanitary Code, at the onset of this report two factors must be mentioned as they have a direct and vital bearing on substantial gains in environmental health in our camp areas this year.

PSYCHOLOGICAL APPROACH:

In working with our growers, crew leaders, and the migrant laborers to improve sanitary conditions, first of all it was essential to know just who controlled, or had influence, within each growers' organization. In some cases, it was a secretary, a general manager, or a bookkeeper. In many cases, in talking to someone other than the grower (owner), much more could be accomplished. EXAMPLE: One grower in our county made the statement that he had not been in his camp for the past five years. How could anyone intelligently talk to this man concerning conditions in his camp. To the growers or their representatives rather than citing rules and regulations, we appealed to their basic human nature - that any person had the right to live in a place fit for human habitation. At times, when absolutely necessary, we pointed out the liability of operating a camp declared unfit or dangerous. The crew leaders were approached with the idea that a clean camp meant a happier and more productive crew. The migrant himself was indoctrinated with the idea that the cleaner his environment, the better he could work - in short, the more money he could earn.

REINFORCEMENT:

By working together as a migrant team, our various project personnel imposed ideas on the growers, crew leaders, and workers. Each member of the team stressed the ideas of the others. This has been a definite advantage in obtaining our overall goals.

Let's look at where we are and what has been accomplished with reference to:

(A) Buildings: Three of our four migrant camps are cement block construction. At the close of last season they were all in fairly good condition with the exception of screens and windows, and in some cases, broken doors. During the summer months, these camps were locked and/or boarded to prevent further damage to the premises. Our Environmental Health Specialist found it very difficult to obtain major repairs during the dormant period. Growers were reluctant, due to the excessive amount of damage that usually occurs during the summer months. However, in the early fall, after many conferences, work began. Each and every camp was completely cleaned and restored, all broken windows, screens, and doors were replaced or repaired. Buildings were painted where necessary and roofs tarred. Grass around the camp area was mowed and the debris removed. Our migrants returned to clean camps. It apparently had a psychological effect as camps in general were kept cleaner throughout the season.

Johnson's Camp, the one blight in Sarasota County, is composed of wooden shacks, of which most are beyond feasible restoration. The only solution to this camp is complete destruction. Acting with this in mind, our Environmental Health Specialist, after many hours of talking and working with the owners, obtained permission to burn each and every vacant house, burn as many privies as possible; and to bury all the debris that remained. With the cooperation of the Florida Forestry Service, the Fruitville Fire Department and County equipment, this tremendous task was accomplished. As of this date, only 31 of these shacks still remain. Our agreement still stands and as houses become vacant, they will be burned. By this process, we feel that in the near future, Johnson's Camp will cease to exist. Our major problem here is what to do with the people after the camp has been eliminated.

(B) Garbage and Trash Disposal: In the past this has been a major problem at most of our camps. Even though cans are provided, pickup and removal was irregular and required continual contact by our Environmental Health Specialist. This department, after realizing that our camps lie within a franchised garbage service area, contacted the Williams Disposal Service Company, which covers Fruitville and our migrant area. A special rate was obtained which made it economically feasible for each camp owner to have regular twice-a-week garbage collection. This required a great many hours of time, taking the General Manager of the disposal company out to the camps, showing him the problem, and getting the company to agree to this reduced rate. The growers were then contacted and the entire idea sold. So, as of this date, our three major camps, with the exception of Johnson's, have twice-a-week regular disposal collection. This has eliminated 90% of our garbage refuse.

(C) Plumbing: Prior to the opening of our three major camps, all septic tanks and grease traps were pumped. New drain fields constructed where needed. (Our major problem here, which will be discussed further under Health Education, is the misuse of plumbing fixtures.) Our migrant team has worked hard on this problem this year, and we feel that our efforts have greatly reduced unnecessary abuse, proving to our growers that through our migrant team effort, we can - in fact - save them the expenditure of useless money.

(D) Water Supply: This is not really a serious problem in our migrant camp areas as most of our wells are deep and the water is bacteriologically satisfactory. However, periodical checks are made of all private water supplies, and when returned unsatisfactory, chlorination instructions are given. Repeated samples are taken till a satisfactory report is returned.

Johnson's Camp water supply had to be chlorinated four times this past year. Twice this procedure was done under the direct supervision of our Environmental Health Specialist - On the fourth try the chlorine residual was raised to approximately 300 PPM and allowed to remain in the distribution system twenty-four hours. Since that time the water has tested satisfactory.

(E) Sewerage Disposal: Here again, with the exception of Johnson's Camp, which still has pit privies and which for the most part are still insanitary; all our migrant camps now have either the Sani-Jon chemical toilets, or inside toilet facilities. Here again, it was through the efforts of our migrant team that this became possible. We took it upon ourselves to contact the Sani-Jon Company, obtain special rates, determine the amount of Sani-Jons needed and sell the idea to the growers, this was accomplished. The old pit privies were then removed.

(F) Rabies Control: It was brought to the attention of our Environmental Health Specialist that many stray dogs frequented the camp area. No one knew exactly to whom the dogs belonged, but they were able to live off scraps, bones and garbage that had been strewn around. The animal control officer was contacted and after several visits, 21 of these animals were permanently removed from the area. This sort of effort is appreciated by the camp owners. It is one way that we can do something for them, something they don't necessarily ask for or require.

(G) Rodent Control: A rodent control program was initiated last July, and remains in effect. Periodically, poison is placed in the camp areas out of the reach of children. In one home in Johnson's Camp, some 17 rats were found dead within the home. Upon conferring with the Rodent Control Expert, it was estimated that this would represent only 1/10 of the total number of rats killed; which would mean that 170 rats in one home alone had been killed. We have no way of knowing the total number of rodents eliminated; however, we do know that we have used a tremendous amount of poison, and it has all been eaten.

Let's see where we stand camp per camp:

FANCEE FARMS:

This camp has barracks type rooms housing single male and female Mexican and Negro workers. Population varies but reaches as high as 60 at some times. This camp has destroyed its one pit privy and is now serviced by Sani-Jons. The property on which this camp is located had to be rezoned which took many, many hours of time, and was rezoned from agriculture to multiple home dwellings. This was done in order that the camp could be enlarged, or that houses for families could be constructed on the property. Fancee Farms has twice-a-week, regular garbage collection. The camp area is much improved, and kept much cleaner than it has in the past. Showers are available, hot and cold running water is provided in all the rooms.

SABABO CAMP:

By far our best migrant camp is this area. During the winter it had a full-time maintenance man working in Sababo Camp. His sole job was to clean the entire camp before reporting to the fields for work. This camp is composed of 20 one-room family quarters and at times houses over 100 occupants. The camp has adequate laundry and inside toilet facilities and they are well maintained. It also has twice-a-week garbage collection.

KEYSER'S CAMP:

Here, in the past, a great deal of malicious damage has occurred - this has been greatly lessened this year. Again, we feel through Health Education. The fact that the camp was very clean when the migrants arrived, they appreciated it, and they have made great strides towards keeping it that way during the year. During the fall, five new drain fields were installed;

septic tanks pumped and all four grease traps cleaned. It has approved showers, and has replaced its privies with Sani-Jons. Here again we have weekly garbage collection.

FARMERS HOME ADMINISTRATION HOUSING PROJECT:

As has been mentioned, one problem which has already occurred at Johnson's Camp is: What are we going to do with the people if we destroy or eliminate the shacks. Realizing this, we embarked on a program to find some method of providing adequate housing, especially for families. Farmers Home Administration was put into effect. Three crew leaders, and their families, applied for a Farmers Home Administration loan to build three bedroom, cement block homes in the migrant area. We were very fortunate in that the growers donated the land upon which these homes are to be built. I think this is further proof, not only of the cooperation which we are getting from the growers, but of their sincerity of providing adequate housing for their migrant workers. As of this date, two loans have been approved, and pending title insurance, construction of these homes will begin within 30 days. This has been a major project for our Environmental Health Specialist as all of the property upon which these homes are going to be constructed had to be rezoned or have special exemption to present zoning. This required going before the Planning Commission and explaining to them the need for the homes in the area, that we were trying to provide better housing for our migrants in order that Sarasota County might attract better workers which would mean better community citizens. While this took time, the job was done and eventually the Board of County Commissioners passed both the rezoning and the special exception to the zoning. It is felt by this department that this is the real major step forward. These homes, as stated, are three bedroom, cement block, with formica kitchen cabinets and ceramic tile bathrooms; with optional carport or screened-in porch. The payments range anywhere from $42.00 to $45.00 per month, which we feel is well within the reach of the migrant worker. It is felt that once these three homes are constructed and other workers see them, they too are going to want a home similar to these, and it is believed that an entire housing project can be started in this area which could involve as high as 50 to 75 homes. Even though the father may have to travel with the stream, the mother and children will remain here. The children will remain in one school. This is a major advancement in the goal to stabilize our migrant workers.

In conclusion, by utilizing our psychological and reinforcement approaches, we feel that substantial gains have been made in the relationship between our migrant team and our growers, crew leaders, and migrant families. The growers are far more aware of the necessity of better housing in order to attract better workers. We have proven to them that we can do the job in helping them save money on their camps by their providing services for their people, and by seeing that these services are properly utilized. With the advent of mechanization, the growers have realized that in the coming year even more has to be done in the way of environmental health in order to continually attract a higher class of worker. It will take a more intelligent worker to operate the new machinery which we all know is coming, than it does to do work which is done strictly by hand.

Two major problems face us in the coming year:

(1) Through the destruction of the homes in the Johnson's Camp area,

ENVIRONMENTAL HEALTH

TABLE I

Number of Camps	4
Number of Camps Permitted	3
Number of Camps Non-Permitted	1
Child Care Centers	1

TABLE II

Camp Visits	41
Nuisances Corrected	62
Plumbing	7
Food Processing	2
Private Premises - Visits	30
Public Premises - Visits	76
Bacteriological Samples	23
Private Water Plants	6
Complaints	82
Rabies - Animal Bites	6
Septic Tank Repairs	21
Garbage Disposal Systems	7
Child Care Center Visits	3

ENVIRONMENTAL HEALTH

CHART I

	CAMPS	# CHEMICAL TOILETS	# APPROVED PRIVIES	# UNAPPROVED PRIVIES	SAT. WATER SUPPLY	INDOOR TOILETS	UNAPPROVED SHOWERS	# HOUSING UNITS
(A)	FANCEE FARMS	0	0	1	YES	NO	NO	6
	SABABO	0	(*) 0	0	YES	YES	YES	20
	JOHNSON'S CAMP	0	0	52	NO	NO	NO	45
	KEYSER CAMP	6	0	6	YES	NO	NO	21
(B)	FANCEE FARMS	1	0	0	YES	NO	NO	6
	SABABO	0	(*) 0	0	YES	YES	YES	20
	JOHNSON'S CAMP	0	6	10	YES	NO	NO	31
	KEYSER CAMP	6	0	0	YES	NO	YES	21

(*) Central Toilet

(A) Beginning of Project Year

(B) End of Project Year

and the fact that our agricultural industry is on the increase, more migrant workers are entering our area. We have discovered, within the past month, three large buildings in the Newtown Negro section of Sarasota County, which house migrant workers. This was entirely unknown to us. This housing, to say the least, is substandard and worse than anything else we have in Sarasota County. But the locating of these people is difficult. To tabulate the number of people living under these conditions is equally difficult and will be a task undertaken this year.

(2) Another problem is field sanitation which we have not concentrated enough time on but will attempt in the coming year to bring a little more into the limelight and work towards better and more sanitary field conditions.

HEALTH EDUCATION

Efforts in Health Education have taken a twofold course this year - educating the migrants themselves and educating the community to the needs of the migrant laborers. It is felt that many more hours are spent in Health Education than are spent performing our specific duties as public health nurses, environmental health specialists and clerk-typists. Here are a few examples to justify our reasoning.

(1) Proper garbage storage and disposal is essential in migrant camp areas, and one of the major problems of a sanitarian - or is it? It was relatively simple to contact the local garbage disposal company, arrange for a reduced rate per can, and sell the entire idea to the camp owners. For every hour spent making this a reality, many, many more hours have been and will be spent educating the migrants themselves. Teaching the people to put the garbage in the can is far more difficult than obtaining the services. Proper wrapping, replacing lids, etc., these are problems in Health Education and require continual contact and timeless effort.

(2) With the exception of Johnson's Camp, all migrant camps within our area have either interior toilet facilities or chemical toilets. Proper training in the use of these facilities is far more time consuming than obtaining them. Example: Soon after arriving at a migrant labor camp it was noticed that one Spanish crew was disposing of soiled toilet paper alongside the commodes. Upon investigation it was learned that their previous toilet facilities could not accommodate toilet paper. The migrant crew was advised that our septic tanks were capable of handling toilet paper and the problem was solved, through Health Education, not sanitation.

(3) Most camp owners are willing to make periodic repairs to screens, windows, doors, and buildings in general. The problem arises when they see their money and efforts quickly destroyed. Where malicious damage occurs, not normal wear and tear, Health Education is the only answer.

(4) We feel there is a tremendous potential in the field of family planning. Health Education, particularly with the male, has been lacking due to the difficulty of communication. Many migrant men are reluctant to discuss conception methods with nurses, as demonstrated by the fact that even though a nurse has convinced Mrs. X to use forms of conception control, Mrs. X returns home and the husband says no. In the case of a Spanish family this decision is usually final. Here our environmental health specialist has proved to be of tremendous value.

(5) When three cases of hepatitis occurred in one camp, both our public health nurse and environmental health specialist made joint night visits to the camp counseling the migrant families in methods of protection against this disease.

In planning for an evening Family Medical Service Clinic and a Child Care Center, it was apparent that much work in public relations would have to be done to enlist community support. All members of our migrant team spent many hours showing all aspects of our work with the migrant population. The time spent presenting these lectures brought bountiful rewards. Since January, 1967, 31 churches, 37 individuals, and 14 business firms have contributed

$3,019.85 for repairs to the building, for the building fund and for supplies for the Day Care Center. A group of men donated 2,220 man hours of labor putting the building into usable condition, and 66 women volunteered 6,880 hours in the Child Care Center. In addition to this, several physicians donated cartons of sample medications to the clinic,

Concomitantly, on February 1, 1967, the church women opened the FAME Day Care Center with volunteer help plus contributed food, money, equipment, and supplies. Within a few weeks this center was serving up to 45 children and infants of migrants in the area each day from 6:30 a.m. to 6:30 p.m., except on Sunday.

Children are given two substantial snacks daily and one full mid-day meal. Children's care, preparation of meals, and donation of food is accomplished mainly by volunteers.

One VISTA worker gives full-time to the center when the number of children is very large; two paid aides are employed for infant care and a paid cook, all from the migrant community, assist on a temporary basis, dependent on the funds from volunteer contributions.

The overwhelming acceptance by the migrants of our Family Health Service Clinic has been obvious from the large attendance at clinic sessions and because of the many migrants that plan to stay over in Sarasota County. Many of our patients have returned from distances as great as 200 miles to attend our clinic and receive health services. It is believed these conditions create an ideal situation for future Health Education programs.

HEALTH EDUCATION

TABLE I

TYPE OF SERVICE	PUBLIC HEALTH NURSE	ENVIRONMENTAL HEALTH SPECIALIST	CLERK
Talks	6	6	2
Conferences	57	299	30
Audio Visual	5	3	-
News Articles	2	10	-
Meetings - Participant	24	48	12
Meetings - Spectator	12	18	4
Exhibits	4	-	-

HEALTH EDUCATION

TABLE II

ENVIRONMENTAL HEALTH SPECIALIST CONFERENCE BREAKDOWN

GROWERS	CREW-LEADER	MIGRANT LABORER	GENERAL MANAGER	OTHER	STAFF CONFERENCE
48	22	83	33	113	47

SURVEY OF A TYPICAL MIGRANT CREW

In cooperation with the migrant team, this survey was taken on February 21, 1967, by Mr. Tony Gomes (VISTA worker), of a Spanish crew.

TOTAL NUMBER OF PEOPLE (including children)---------------------------- 77

AGE	MALE	FEMALE		NUMBER
0 - 16	11	9		20
16 - 21	23	11		34
22 - 30	5	3		8
30 - 40	9	3		12
40 - 50	1	0		1
50 - 60	0	0		0
60 +	1	1		2
			TOTAL	77

SPANISH CREW

The oldest is 67-the youngest is one week:

25.97% are between the ages of 0 and 15
44.15% are between the ages of 16 and 21
25.97% are between the ages of 22 and 40
3.90% are between the ages of 41 and 67

EDUCATION:

Each worker was asked for the number of years he or she had attended formal classroom education. In those cases where the person studied in Mexico and the United States, the total number of years was used. This part of the survey applies only to those workers who are 16 or over, since all school age children are presently registered in one of Sarasota's public schools.

The average number of years of school attendance was 3.21. The highest was one high school graduate and the lowest was 13 workers who had never attended school. There was one member of the crew attending school at the present time. He was 17 and a working member of the crew.

HOUSING:

A total of 21 rooms are available to house the crew. This means there is an average of 3.66 people per room.

SANITARY CONDITIONS:

A total of 8 shower connections are shared, for an average of 9.62 people per shower.

A total of 12 toilet bowls are available for an average of one bowl for each 6.41 people.

This survey is only one of many received by our department. However, it does show the tremendous value of a good VISTA working in your area. Mr. Gomes is such a man.

THE FUTURE

We plan to continue this program along the lines established this year. Those objectives substantially achieved will be consolidated, strengthened, and continued. Those objectives either partially achieved or clearly not established will be further stressed over the summer and next season. This summer we plan to make every effort to find migrants or migrant families which have "Summered over" in our county. As migrants arrive next season, we plan to try to establish a registry in order to assure contact with all our migrants to include seasonal agricultural workers who may stay in our area year round but work as migrants during the period October - April 30. Our medical clinic will be firmed up on a regularly scheduled basis starting in November and continuing through April. Major efforts will be expended to start a basic FHA housing program for migrants who wish to settle in our area. The father and older sons may well move into migrancy during Florida's off-season, but will leave the rest of the family at "home". We hope, above all, to complete the removal of Johnson's Camp as a blight to our community during the next 12 months. Field sanitation facilities will be encouraged in the coming season.

We feel our project has established itself as a community force and that it will continue to provide appropriate services so long as needed. We now want to move toward some of the less obvious activities which will eventually make the agricultural worker a welcome contributor to the general welfare of our entire county.

SUMMARY

The early months of 1966 were filled with conferences with community leaders and volunteer groups, evening health education programs for the migrants, and household surveys in each camp. Much time was spent by the environmental health specialist assigned to this program encouraging the cooperation of the labor camp owners and growers in improving environmental health standards.

We planted the seeds hopefully in those early months, and with the coming of spring, the seeds began to sprout. Regular evening immunization clinics and health education programs were being conducted. Mass tuberculin testing was begun in several open-air clinics. The mobile x-ray unit was brought to the migrant area and 166 farm workers received x-rays. Social clubs for the women and children were organized, with the improvement of living conditions as their goal.

A "clean-up week" was initiated by the Environmental Health Section, in cooperation with the County Public Works Department, public health nurse, VISTA volunteers, and residents of the camps. Areas were cleared of garbage, refuse, and trash that accumulated for years. In many instances the accumulations had reached a depth of five feet. Heavy equipment was utilized to dig trenches and bury tons of debris. VISTA workers helped residents construct approved sanitary privies.

In the spring permission was obtained to control-burn the entire area of Johnson's Camp and to destroy all uninhabited houses. Vast areas east and west of the camp were cleared and burned. Thirty-five houses and numerous privies were destroyed. Cooperating in this venture were the Florida Forestry Service, Fruitville Fire Department, County Regulatory Service, Public Works Department, and the health department.

In July, a rodent control program was initiated. Rat poison (warfarin) was placed in all camps. This, in addition to the controlled burning project, was a big step forward in controlling the insect and rodent population in these areas.

A "well-baby" clinic was established in July and is conducted the second Monday evening of each month. Meetings were held with volunteers and arrangements were made for transportation of patients for appointments with dentists, local physicians and the Planned Parenthood clinic.

In order to stimulate interest in new migrant housing, a meeting was arranged between members of the health department, County Regulatory Services, the major growers in this area, and a representative of the Farmers Home Administration. Our environmental health specialist assisted the owners to initiate the necessary zoning changes and coordinated these activities with the builders, so that the FHA loans were approved and construction will begin in the near future. Here again, we feel that this is a major breakthrough in the growers' attitudes toward both their employees and our migrant team efforts.

At the end of October, it was decided that somehow we would have a general medical clinic in operation by the first of December. At this time we had no building, no funds, and no doctor to staff it!

In a few weeks, through the efforts of our environmental health specialist, a piece of property and a building were donated for the clinic. A beginning! Small, to be sure, but we had already seen the results of planting the smallest seeds, nurturing them with plenty of hard work and determination, and watching them sprout forth in full bloom.

The community support has been overwhelming, as churches and individuals pitched in to help rebuild our old barn of a building. Four clinic rooms have now been rebuilt and furnished, and a large educational area is nearly completed.

ENTHUSIASM - the word that has sparked this endeavor from the beginning - led us to hold our first migrant medical clinic on Monday might, December 5, before the building was even finished. The fact that we had no running water didn't stop us from holding an unbelievably successful clinic, with 46 patients attending. Screening tests were done for tuberculosis, hemoglobin determination, and diabetes. Patients were all given tetanus immunizations and polio vaccine. Our health department venereal disease investigator worked the clinics with us and took blood tests on all patients. At our first clinic, thirty complete physicals were done by the physician; all clinic sessions were very well attended; the average attendance was over 30.

The staff consisted of the public health nurse, environmental health specialist, and clerk assigned to the Project plus volunteers including nurses, staff social worker, staff V.D. investigator, translators, VISTA worker, and the Director of the Sarasota County Health Department. Two clinics were held in December, two in January, four in February, four in March, and two in April. In these fourteen clinic sessions, over 450 patients were served.

And at last we have a name! Fruitville Area Medical and Educational Center. "FAME" Center and "FAME" Clinic will be the hub of our busy migrant area. Our long-awaited child care center was opened in cooperation with community groups, and community school classes will be set up at night.

The closer relationship between our migrant team, growers, crew leaders, and the migrants themselves seems to be having its effect. Giving them the feeling that "someone really cares" may prove to be the solution to many of our migrant labor problems.

Clinic physician examining infected ear.

Project nurse taking medical history.

V.D. Investigator performing VDRL on migrant.

Nurses performing laboratory work.

SEMINOLE COUNTY HEALTH DEPARTMENT

Frank Leone, M. D., Director

Area of County:	352 square miles
Resident Population:	67,500
Number of Migrants:	12,500
Migrant Project Staff:	2 Public Health Nurses 1 Sanitarian 1 Clerk-Typist

DOMESTIC AGRICULTURAL MIGRANT SITUATION IN PROJECT AREA

SEMINOLE COUNTY

Seminole County is located in central Florida and has a population of 73,000 residents within its 352 square miles. The migrant population is estimated at 12,500 - 98% Negro and 2% Anglo. Agriculture is the main source of income and principal activity of the county. Seminole County ranks fourth in Florida in the value of vegetables for sale.

Farms have increased in number from 726 in 1964 to 800 in 1966. The on-farm value has grown from $11.5 million in 1960 to $16.2 million in 1965. The agri-business value of the Seminole County agricultural firms is over $49 million. There are some 22,000 acres of citrus land in the county which is worth $7 million. Seminole County had the best citrus season (1966-1967) in many years.

Seminole County produces about 40% of the nation's watercress and is the winter home of the nation's second largest watercress producer. The Hunt Canning Company built a million-dollar plant in Sanford several years ago which has since doubled in size. All this has brought about an increase in the migrant population. Sanford is our county seat and the location of a large State Farmer's Market.

Vegetable crops include: Celery, watercress, cabbage, beans, lettuce, squash, corn, peppers, cucumbers, tomatoes, eggplant, carrots, some cantaloupes and watermelons, and also blackberries. Planting begins in early September and harvesting extends through the middle of June; some vegetables having a second planting.

Near freezing temperatures in early November caused some loss to tender crops like beans, cucumbers, and squash which were burned; the "cukes" were hit the hardest. In late February, a freeze damaged lettuce, peppers, and eggplants which had to be replanted. Cabbage, celery and citrus escaped with little harm. Cabbage has surpassed celery as our number one crop.

There is significant mechanization development in celery harvesting with celery cutting about 80% mechanized. The "Shaker," an automatic fruit (citrus) picker has been developed by a company of Oviedo, in Seminole County. The "Shaker" arm is put on the limb, the tractor operates the arm, and the fruit falls to the ground. Crews move in rapidly after the operation to gather fruit off the ground. This new equipment will be used where fruit is to be picked for juice and canning.

> (1 & 2) Peak employment is in February and March due to citrus picking, at which time there are 12,500 migrants. The average number working on farms is about 2,500. About 600 extras come into the area for a very brief period during the heavy crop harvesting season. Non-working dependents number nearly 8,000 - 2,650 of whom are children.
>
> Our migrant workers begin leaving during May with the heaviest migration in June after school closes. Their destinations are along the East coast to New York and Ohio, a few go as far as Michigan. With the completion of

the apple harvest in these states in September, they start back arriving in late September and October.

(3) At least 75% of the farm workers living in Seminole County, either own or rent the dwelling. There are no licensed camps in the county; however, we have one camp in the area of the clinic which houses 120 migrants at the grower's expense.

(4 & 5) There are several heavy migrant concentration points besides the Midway section where the clinic is located. One of these is Oviedo with a migrant population of approximately 3,000; Monroe has 3,000, and Altamonte has 2,000. The one and only camp was visited twice a month.

(6) Mechanization in the harvesting of celery has been going on for some time, the celery must still be cut by farm workers. Mechanized citrus picking is in the very early stages. There was a greater number of citrus pickers this season due to the exceptional abundance of fruit on the trees. With the increase in farm acreage and citrus groves and the steady increase of migrants as well as their distribution in the county, we will not only need to continue this project but expand it by adding another clinic in the South Seminole area (Oviedo).

Certainly, we profit by migrant labor. Much of the food that reaches our table is harvested by migrant workers. We all have a responsibility for them and their families in helping to identify their health problems and to meet and treat them. They are people who live and love, and hate and laugh, and hurt and long, and dream, just as you and I. Instead their lot is worry, strenuous work, overcrowded housing, and poor sanitation, plus lack of medical care and facilities.

A clinic facility has been acquired in the heart of the largest migrant (crop) area; Midway, to brighten the migrants health future. A primary requirement of a good outpatient clinic is that it be available to the people who are being served. This is essential. Clinics should be strategically located and open during hours reasonably convenient to the people who will use them. Unless the hours coincide with the times people can attend, treatment and the necessary follow-up will be difficult, if not impossible.

FAMILY HEALTH SERVICE CLINICS

The specific objectives of this program are to provide basic health services for the migrants, adapting these to the socio-cultural characteristics of this labor group, and to develop additional services as indicated. The project is primarily to bring medical, dental, sanitation, and health education services to migrants. We must teach these people how to live so that they don't get ill and don't make each other ill. Effective public health work with farm migrants depends on offering a variety of health services during one visit to the health clinic.

(1 & 2) A clinic facility has been acquired in the heart of a large migrant area which is serving as a drop-in health center on the site so that residents of the area can get acquainted with the health personnel and the services available. The clinic is in a store which was remodeled and equipped to render medical services. It consists of

three rooms - a waiting room, treatment room, and a large examining room divided into adult and child cubicles. There is also a large storage area with shelves for medications and educational literature, pamphlets, posters, flip-charts, etc.

There are two day clinics and two night clinics weekly. Two nurses and a clerk-typist serve the day clinics, one of which is in the morning, the other in the afternoon. The night clinics are from 7:00 p.m. until approximately 10:00 p.m. and are served alternately by six different local physicians, our two nurses, and the clerk-typist. All services are offered free of charge to all migrants.

Clearly, if the poor are to benefit from the best of modern medical care, attention, money, and action must be focused on the development of better ways of organizing and delivering care. If there is a single point that has become obvious in our work locally, it is that health services must be designed to meet the needs of the users of services. The following basic public health services are offered; namely, communicable disease control (immunizations), prenatal and postpartum care, venereal disease (blood serologies and smears for GC), epidemiologic services, screening for cervical cancer (cytology smears), family planning, child care including examination for worms, nutrition counseling, tuberculosis casefinding, glaucoma screening, visual and auditory screening, mental health services, dental care, chronic disease control, health education, some laboratory work, x-rays and home visits, environmental health services, and protection in housing and sanitation.

In other words, we have established a program of family health services available in our clinic to prevent and treat illness at a place accessible to these migrants.

The use of auxiliary health workers, Negro Gray Ladies, trained volunteers, in our health care system were utilized. They were used in educational and preventive programs. Their greatest value is that they greatly facilitated communication. They understand their own and know their cultural patterns. Using these people from their own groups helped to improve the habits of these seasonal agricultural workers. These aides were very effective in improving sanitation conditions and stimulating use of the available health facilities at the clinic. The inability of the professional to communicate often limits his capacity to treat and hinders his ability to heal. Because of their native intelligence, these trained volunteers can be very effective health workers.

(3a) There were 75 evening clinic sessions with physicians in attendance on a fee-for-clinic-session basis and 77 day sessions with two nurses in attendance. The evening sessions averaged approximately two-and-one-half hours, the day clinics are three-hour sessions.

Total number of clinic visits.................................. 3,514

(3b) Total number of individuals seen in clinics throughout the project report period:

Number seen by nurse only.. 1,691

Number seen by physician and nurse........................... 1,823

Number seen by others.. -----

(4) Persons treated in clinics during project report period.... 2,029

	0-15 Yrs.		15-44 Yrs.		45 + Yrs.		TOTAL	
SERVICE	M	F	M	F	M	F	M	F
ARTHRITIS	-	-	3	5	8	9	11	14
ASTHMA	2	3	1	6	4	8	7	17
NUTRITION	19	30	11	8	9	13	39	51
VENEREAL DISEASE	3	1	82	27	6	1	91	29
INTEST. PARASITES	131	124	40	31	-	-	171	155
DIABETES	-	-	2	8	4	21	6	29
TUBERCULOSIS	-	-	1	-	2	2	2	3
CARDIO VASCULAR	-	-	7	26	12	52	19	78
G.U.	-	5	3	10	7	4	10	19
HYPERTENSION	-	-	10	20	16	27	26	47
PYODERMA (SKIN)	57	71	8	24	11	6	76	101
RINGWORM (SCALP)	36	6	-	-	-	-	36	6
INJURIES	31	23	8	11	2	6	41	40
COLDS & SORE THROAT	187	231	38	58	7	12	232	301
EAR INFECTIONS	63	47	11	24	2	3	76	74
EYE INFECTIONS	11	7	6	1	-	-	17	8
ALLERGIES	9	5	6	8	-	-	15	13
ORTHOPEDIC	2	8	4	9	-	-	6	17
GYN	-	19	-	32	-	7	-	58
G.I.	23	34	6	12	7	6	36	52

(5) Persons referred to other sources of service during project report period 27

	0-15 Yrs.		15-44 Yrs.		45+ Yrs.		TOTAL	
	M	F	M	F	M	F	M	F
PRIVATE PHYSICIANS							10	17
Skin	-	3	1	1	-	-	1	4
E.E.N.T.	1	1	-	-	-	-	1	1
Heart	-	-	-	1	-	1	-	2
Orthopedic	-	1	-	-	-	-	-	1
OTHER (Including Minor Surgery)	2	2	5	4	1	-	8	6
PRENATAL	-	-	-	3	-	-	-	3
DENTIST	22	19	60	70	-	-	82	89
HOSPITAL X-RAY	1	-	3	-	1	1	5	1
HOSPITAL EMER. ROOM	4	1	7	3	4	1	15	5
NUTRITIONIST	-	-	-	2	-	1	-	3
FLA. CRIPPLED CHILDREN	-	1	-	-	-	-	-	1
FLA. COUNCIL FOR THE BLIND	1	-	-	-	-	-	1	-

As the chart shows, migrant referral services were varied. Arrangements for carrying out referrals were made by telephone, by mail, by project nurses, and by the individual migrant.

We are pleased to report that most of the individuals cooperated well in completing referrals, keeping appointments, carrying out individual instructions and reporting back to clinics.

Most of the referrals to private physicians were to specialists who concurred with the diagnosis of the clinic physicians, gave immediate treatment and instructions for the patients to return to the clinic.

To date, we have only one referral which has not as yet been completed. This is a child who is on the waiting list for the Florida Council for the Blind.

(6) Examples of purposes and methods of educational effort:

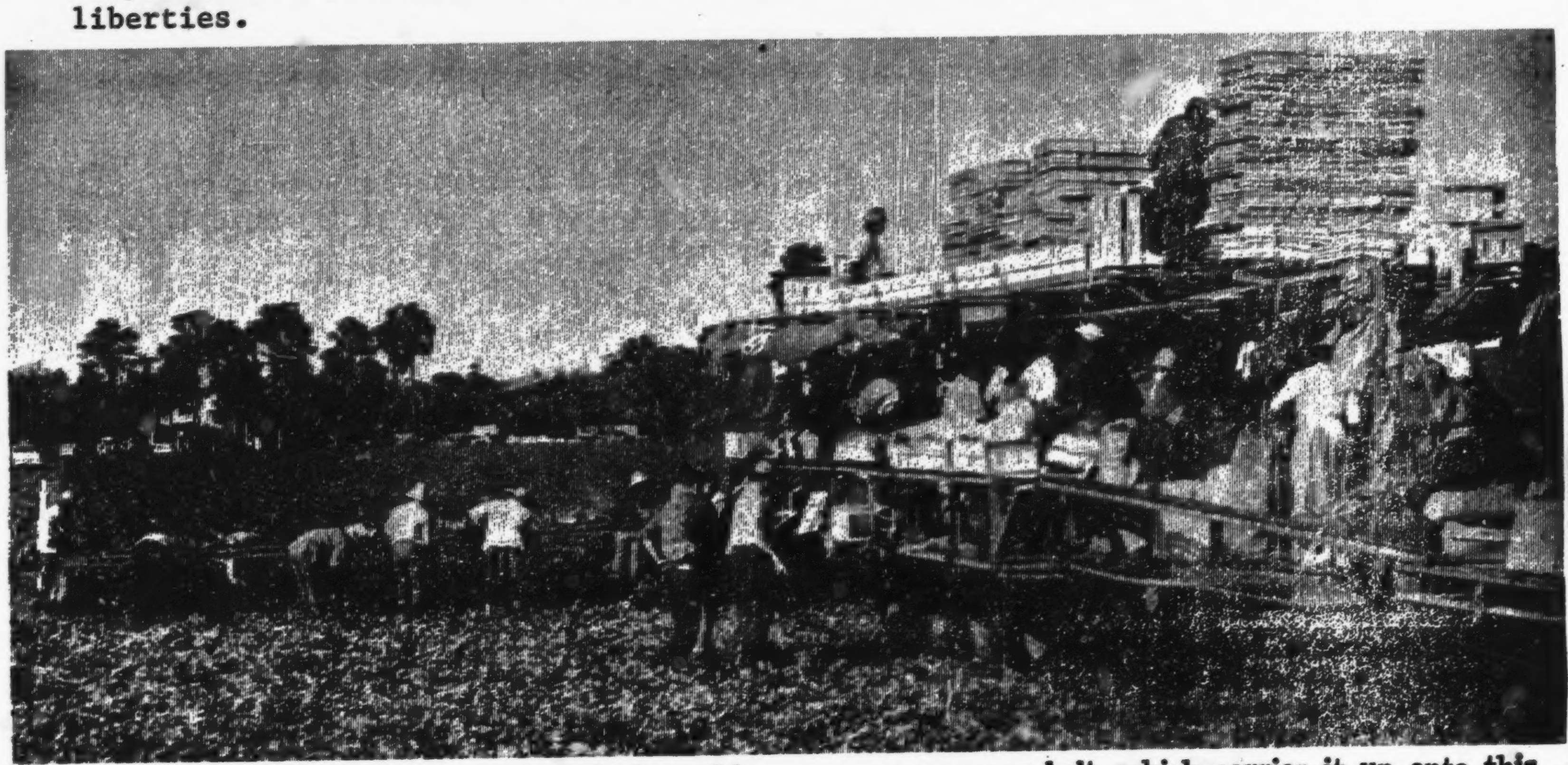
The problem is to bring people and care into contact. They must learn to become self-sufficient individuals. Their greatest need is for simple practical health education as to personal health habits, sanitation, diet, prenatal, and child care; preventive measures to combat infection, etc. Malnutrition is common. Virtually every patient has a low hemoglobin. More than half have very poor diets. Many of the diet problems are centered on the lack of money to buy sufficient food and on poor choice of food. Our nutritionist provides individual and group counseling with patients arranging nutritious menus, etc. within their purchasing power. Posters are displayed and pamphlets distributed. Similar arrangements are made with maternity cases and children.

Films are shown on the spread of disease due to poor sanitation and how to improve environmental conditions and prevent illness.

Venereal disease films and talks with question-and-answer periods and leaflets are also held.

Flip-charts are used in family spacing classes for women, which are well attended and welcomed. Probably no more important thing is happening, which will have a solid impact on the question of poverty, than this recent trend toward smaller families among low-income families. This may hopefully change the lives of these people for their betterment.

Talks are given by nurses on why it is important to seek early treatment for injuries and illness. Talks are held on diabetes, tuberculosis, heart conditions, high blood pressure, worms - and their causes, prevention and treatment. Our dentist presents films and talks on oral hygiene and dental care and with a model demonstrates the proper use of a tooth brush. One needs to be educated in order to develop and protect one's health, and one needs abundant health to make full use of one's education. It is a reciprocal relationship. Good health is a necessary preparation to cope adequately with the everyday problems of life and for getting and holding good jobs. Education will help remove the shackles of poverty. Health is a way of life that demands concern and cooperation. In health there is freedom. Health is the first of all liberties.



"MULE TRAIN" is the nickname applied to this all-in-one operation for celery harvesting on a Chase & Company farm. Pickers place the celery on a conveyor belt, which carries it up onto this truck for washing, cleaning and boxing.

2-67

(7) A special effort has been made to counsel with and teach patients on a personal basis. Each patient is given instructions regarding their condition, importance of follow-up care, purpose of medication, and need for responsibility toward personal health habits and proper sanitation.

Individual counseling on specific problems; Our nutritionist counseled with forty-seven (47) persons, both individually and in groups as to diets, food, and menus. These included the obese, prenatals, diabetics, cardiacs, and children.

SUBJECT OF COUNSELING	NO. COUNSELED
Nutrition	47
Maternity	48
Child Health Services, Including preschool round-up	99
Family Spacing	32
Venereal Disease	24
Tuberculosis	3

(8) Group counseling is given monthly with the use of audio-visual aids, leaflets, demonstrations and speakers, relating to immunizations, prenatal care, family planning, communicable diseases, good health habits, sanitation, and housekeeping.

TYPE OF GROUP	NUMBER OF SESSIONS	TOTAL
Family Planning classes	9	32
Prenatals	18	48
Child Health clinics	18	39

Nurses made 241 visits to the homes for the following conditions:

Infant care -- 60
Preparation of the home before the babies' arrival ---------- 48
Prenatal conditions -- 17
Illness, varied -- 30
For communicable diseases ------------------------------------ 29
T.B. follow-up -- 6
Chronic diseases (cancer, diabetes, C.V.D., etc. ------------ 51

Thirty-seven (37) cervical smears were done to screen for cervical cancer. One case was confirmed by biopsy.

One-hundred one (101) were screened for Glaucoma, two (2) cases were confirmed and one (1) is under treatment, three (3) suspects will be re-checked.

(9) This being our first year, we had no means by which to compare these clinic sessions.

(10) Some of our problems were; not coming in for prenatal care early in pregnancy, not keeping repeat appointments, and ignoring referrals to dentists. Many of these pregnant migrants, especially the older multipara, never made but one or two visits in the past and could not

see the necessity for doing otherwise now. However, through family classes, more stringent regulations and personal counseling, we feel that these people are beginning to realize how important it is to come in and be checked regularly. More explicit instructions with appointment cards and home visits helped the attendance of return visits. It was explained why follow-up visits were important to prevent complications and recurrences. Apathy, fear, and poor communication resulted in delay in seeking dental care but with follow-through, dental attention has been greatly improved. These problems were eased considerably through home visitations by our Negro volunteers.

Often we cannot comprehend why people fail to get adequate medical care. Their reasons, many times are trivial, but trivialities that prevent women from being examined for cancer of the cervix are indeed serious.

We have a lot to learn in motivating people to take care of their health. Finding the answers apparently is not too simple. They may not lie in more of the same things we have been doing. Rather, they (the answers) may lie in efforts to make health action easy for people so that you gain maximum benefits from the health education efforts expended.

The fact that a substantial number of these people are on the move and do not let you know when they will leave, and where they will go, is one of the underlying difficulties resulting in interrupted medical attention. A move is in progress to correct this by explaining to these migrants that services can be rendered to them at their destination if they will give us this information prior to leaving.

(11) Mimeographed sheets stating services rendered, days and hours of clinics with the telephone numbers, distributed by volunteers, also in the clinic and on home visits as well as to crew leaders were very effective in that the response was shown by an increase in the number of patients attending our night clinics. Meetings with parents of the surrounding school auditoriums, describing the project and its convenient services, helped considerably. We feel that progress has been made, to date, in helping these migrants with their health, education, and sanitation. We have been able to do much more for the migrant with this project grant and the staff employed for this purpose.

One must remember Shakespeare's words in Julius Caesar: "The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings."

(14 & 15) Has been answered above.

(16) Our clinic and its equipment is adequate, is working well as to location, clinic hours are convenient, and it is well attended. We cannot see any disadvantages up to the present.

(17) These people are very proud of "their" clinic, they state this often. They are appreciative of the services rendered, praise the thoroughness of the doctors and the courtesy extended by the nurses. Many of our migrants, who remain at home, are taking advantage of "their"

clinic and also encouraging others to attend and even accompany them to the clinic.

Emergencies have been reduced substantially as these people get to know about the clinic. Fewer of these cases have appeared at the hospital emergency clinic and at doctor's offices for emergencies.

(18) We hope we are serving as many migrants as have need for our health care, we are trying hard enough. However, how can we be sure. Surely, with time this hope can be fulfilled. We hold four clinic sessions per week, to date this appears quite adequate. We need time and more time for education and home visits in order to fulfill our objectives. Hospital care for those needing it for acute conditions has always been arranged.

(19) Our suggestions based on this season's experience which might be of help to others in this project in the future are to stress diet and nutrition, continuous medical care, more and more health education, improvement of insanitary conditions - and above all - more attention to children in all phases; that is, studies into the health needs of the poor here reveal too many children suffering health deficiencies which seriously limit school performance, destroy the self-image, and perpetrate indifference and poverty. If we look at these youngsters, we see the "not enough" syndrome - not enough education, not enough medical care, not enough food, money, clothing, not enough love, care and supervision at home. Constant exposure to "not enough" results in an inability to participate and profit from interacting with society. The child is physically, emotionally, intellectually, and socially unprepared for the demands of adult life. The relationship of health education, to successful and responsible citizenship, should receive priority.

NURSING SERVICES IN CAMPS OR OTHER PLACES WHERE MIGRANTS LIVE IN PROJECT AREA

(1) There are two full-time paid Project nurses in this program. The number of part-time nurses varies depending on circumstances, since these are the health department nurses who attempt to render some services to migrants in other distant parts of the county. We have trained Negro volunteers in first-aid, self-help, sanitation, etc., to go amongst their own as well as to hold group meetings to teach, discuss, and stimulate health care.

(2) We have only one camp in the county, which happens to be located close to our migrant clinic. Concentrated migrant housing completely surrounds the project clinic and extends for several miles or more around.

(3) The camp and above areas are visited at least once a month during the season.

(4) Has been answered earlier.

(5) No nursing services were given at the campsite since the migrant clinic is located within six blocks of the camp. The camp, however, is visited weekly on regular schedules by the project nurse. Individuals

found to need medical services are referred to our family clinic.

(6) Twenty-five (25) families were visited during the project operating period and twenty-eight (28) persons were referred to the migrant clinic for treatments.

Conditions found requiring care were:

	Under 15	15 - 44	45+
ASTHMA	1	-	1
INJURIES	1	5	-
G.I. UPSET	4	3	-
VENEREAL DISEASE	-	2	-
G.U.	-	2	-
PREGNANCY	-	1	-
UPPER RESPIRATORY	5	6	1
GYN	-	2	-

(8) Has been answered in Data Sheet #2.

(9) Individual counseling was given with each visit to the campsite whether it was regarding the patient's condition or health habits. It was found that children living at the camp were not immunized, necessitating repeated checking to make sure they came to the clinic for their shots.

(11) Being our first year we cannot make comparison of services with any previous year.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

We have been unable to fill the vacant sanitarian position for the Migrant Project and this, plus having one vacancy on the regular staff, has presented a heavy workload for the existing force. However, since the need to improve sanitary conditions for the migrants is so great, the present staff has spent considerable time working in the migrant areas. We hope the migrant position can be filled soon because in our work we see and find so many problems which need attention and correction but we do not have the time to adequately carry out a complete program.

The water supplies in the migrant areas have been one of our greatest hazards and considerable improvement is being made. The City of Sanford water supply has been extended to the Midway area and 50 per cent of the residents have connected to the system. Approximately 75 per cent of the residents in the migrant area of Altamonte are now connected to a public system. The City of Oviedo is presently constructing a public system and services will be made available to the migrant areas. It takes time to convince these people of the importance of a potable water supply but in time we are sure we can secure 100 per cent connection to these systems.

With the extension of public water to these areas, the installation of inside toilet and bath facilities has increased rapidly. The property owners can secure a water connection for $50.00 compared to $350.00 for a well and pump; therefore, the cost of providing inside toilet facilities is reduced in the amount of $300.00. Elimination of outdoor privies is stressed and requested at all meetings and through personal contacts.

Eating and drinking establishments patronized by migrants have been upgraded during the year. Two (2) establishments have been closed due to insanitary conditions. All establishments were visited and an improvement program outlined with follow-up visits to assure progress was being made in compliance with the outline presented.

The animal control program has not advanced as rapidly as planned. All known stray dogs have been picked up in the migrant areas. There are still a number of dogs running at large without tags. The Board of County Commissioners plans to employ additional labor beginning October 1, 1967, to police the county and strictly enforce the Animal Control Law.

The Seminole County Board of Commissioners has submitted a local enabling act to the State legislature providing for a minimum housing code. Unfortunately, at this time, it does not appear the legislature will pass this bill. We feel this act would enable us to eliminate substandard housing more rapidly. In the event we are unable to secure a minimum housing code improvement, we will continue using the existing building and sanitary codes.

SANITATION SERVICES & INSPECTIONS IN MIGRANT AREAS

Public Water Connections	360
Water Samples Collected	42
Private Sewage Plants	9
New Septic Tanks Installed	46
Percolation and Soil Log Tests	22
Bathing Areas Surveyed	2
Public Swimming Pools Inspected	2
Child Care Centers Inspected	6
Complaints Investigated	12
Eating and Drinking Establishments inspected (22 establishments)	65
Grocery and Meat Markets inspected (9 establishments)	18
Private Premises surveyed	55

All the sanitation services should be increased in order to make significant improvements in the migrant areas. The present services should be expanded and a complete housing survey made in order that factual data could be presented to the growers, officials, societies, clubs, and the general public. Additional educational work should be carried out with growers, crew leaders, landlords, and migrants. Visits to field locations have been limited and this is an important phase of the environmental sanitation program.

A number of problems are encountered in attempting to improve conditions for migrants. Migrants have a tendency to be apathetic and lack responsibility for public or private property. Owners of migrant housing are reluctant to constantly repair and replace sanitary facilities destroyed by the occupants. It appears a great deal of time must be spent in guidance and counseling with these people in order to develop a desire for a sanitary environment.

HEALTH EDUCATION SERVICES

Most of Data Sheet #5 has been answered in Data Sheets #2 and #3. The need for health education materials, consultation on methods, etc., was adequately met with the services of our consultant in nutrition, in tuberculosis, with our psychiatrist, and local specialists. Community groups were very responsive, willing, and able to work with us and the migrants. They worked as trained assistants to the dentist, in the prenatal clinic, in the tuberculosis x-ray follow-up clinic, transporting children and adults to various clinics, house visits to the migrants to keep appointments, to instruct and help with education, etc. Day care centers helped with supervision of children while mothers worked.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

We found a number of individuals who had graduated from elementary school and who had been trained as clinic aides and even in practical nursing who, because of this training, appreciated our goal of self-help and motivation for the individual and his family. They volunteered their services as neighbors and otherwise to preach to the migrants the importance of health and cleanliness and to check on housekeeping standards.

Ministers from their church pulpits helped to motivate these people to come in for health screening and to bring their children for immunizations.

Some teachers volunteered their services by bringing children to the clinic that were infested with ringworm and severe skin infections, worms and with abscessed teeth. The principals of nearby schools referred cases of venereal disease to the clinic. These volunteers mobilized community resources to provide child care and other services for the good of the community. This continued effort to organize people to help themselves and each other and to publicize the program should help these communities to participate in the program. The greatest need in any program is their interest. This project, in the ultimate, is directed toward the well-being of the communities we seek to assist, as well as the people living there. Education in health just happens to be the most important fundamental in all of education.

(5 & 7) We had no experience with any groups obstructive to the project nor language difficulties.

(8) To date, we have not been able to employ a sanitarian since January 1, 1966. Some difficulty is suually experienced in acquiring a suitable facility. One of our health department sanitarians is giving part-time service to the Migrant Project.

(9) Our starting date was delayed due to problems experienced in recruiting project staff, we still have no sanitarian, and in finding a suitable facility which had to be remodeled to allow for clinic services. More professional help should be available in all disciplines.

(10) The migrants are happy with good, convenient, free medical care and free medicines. The growers are pleased to know where to refer these people when necessity arises. The health workers know that there is a facility and community resource to fall back on. Whether this attitude will last will take time to determine.

(11) The leading successes were that with the appropriation of these funds we were able to refer patients for specialist care. We instituted an active dental referral system and could distribute medicine free of charge. Furthermore, we owe a great deal to the physicians who diligently work with us in the clinic and are very cooperative.

(12) The shortcomings were mainly lack of migrant inpatient hospitalization and not being able to recruit a sanitarian.

(13) We received faithful and intelligent volunteer assistance from the people of the target area itself. This is our first year. We feel that we will get better support from the growers as time goes on and certainly our volunteers will continue with us.

(14) The farm bureau, the director, the nurses, our health department sanitarian, the clerk-typist and the volunteers all helped toward the accumulation of data for this report.

(15) We need better follow-through on referrals locally as well as a more intensive effort to seek out migratory cases that need a health service referral form to take with them on the season along the East Coast for continuation of treatment or health services.

SUMMARY

The migrant plays an important role in the economy of the State and of this county. Crops worth millions of dollars would rot on the tree and in the field if migrants were not available when needed to harvest them. The migrant is of immense importance.

His hardships include: Inadequate schooling for the children, lack of identification with the community, limitation of opportunity for advancement, lack of continuous medical care and education, inadequate diet, insanitary living conditions, etc.

The most frequently encountered problems concern nutrition, dental, cardiovascular, disorders of the genito-urinary system, anemias and pyodermas.

Permanent health advances can be achieved only be devoting a large share of the health budget to preventive services. In the long run, improvement in the health of the population will depend on the extent to which the importance of prevention is advanced and served.

The clinic affords a better opportunity to find children with bad oral hygiene and thus, has increased our referrals for dental care.

We have found that ninety per cent of the migrants have no health insurance. Two-thirds have no doctor, and because of this and lack of money to pay a doctor, neglected their ailments. Twenty per cent of the school age migrant children have problems of visual acuity and about five per cent have some degree of hearing loss. Fifty per cent of all two year old children have one or more decayed teeth. Nine per cent of the elementary school children have lost one or more of their permanent teeth. Fifteen per cent of junior or high school students have lost one or more of their permanent teeth.

At the present time in this county, we are participating in major efforts to improve the quality of medical care among the low-income families, and to devise new approaches to the many problems of providing care.

OUR MOTTO: Good Health Services to the Poor

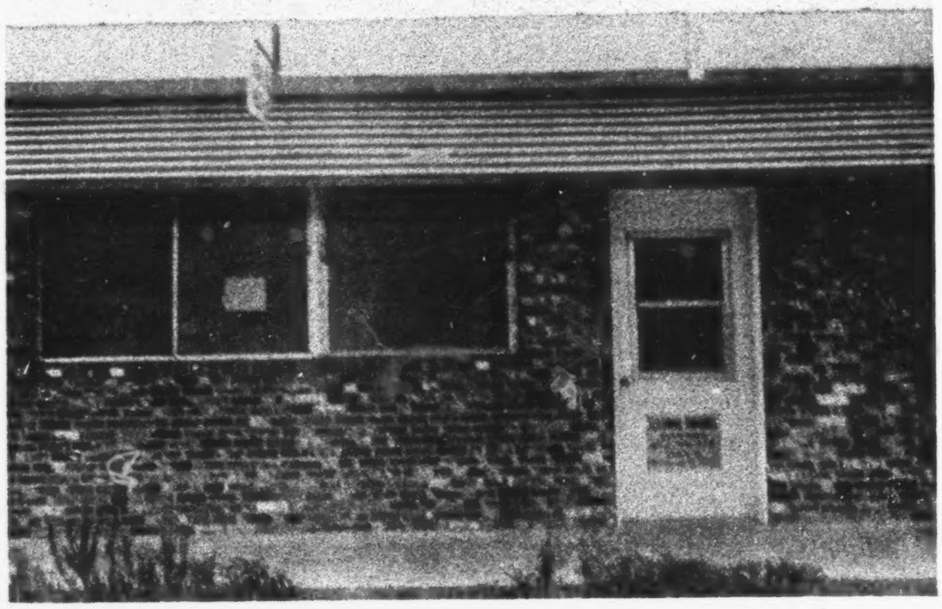
If you are planning for one year - plant rice

If you are planning for ten years - plant trees

If you are planning for one-hundred years - educate the public.

Migrant housing in Sanford,
Seminole County.

Migrant housing in Sanford,
Seminole County.



Migrant Health Clinic, Sanford Area.
Seminole County.

FUTURE PLANS

During the months remaining before the conclusion of this project year it is planned to continue existing activities and expand on them where possible.

The vision, diabetes, and dental screening programs will commence again in the fall when the migrant workers return, and will be continued into next year. A project revision will shortly be submitted for the institution of Inpatient Hospital Care for Migrants. This particular and important feature of the project will be continued through 1968. The tuberculosis sputum screening program which has not been implemented to date, due to lack of aerosol equipment, will begin in the fall with the delivery of the necessary equipment.

In Martin and St. Lucie counties the medical and dental clinics should be operational by summer, providing that no difficulties develop in the recruitment of project personnel and the acquisition of equipment. These two counties will then be included in screening, health education, referrals, and various other activities in which other project counties participate.

It is planned to have the Migrant Health Coordinator and a photographer tour project counties during May to work up a series of slides to be used by project personnel when making speeches to the public concerning migrants and the project services.

A health educator should be employed by July who will be responsible for the planning and implementation of a program of health education directed to the agricultural migratory workers and their dependents in the project counties. He will also prepare newspaper articles and radio and TV programs concerning migrants and the Migrant Health Project for the dual purposes of educating the migrants and acquainting the general public with the project.

Plans have been made to combine the ten Health Service Indexes into one volume and to include West Virginia as the eleventh participating state. The Referral Form now in use will be revised to assure more completeness and will be distributed to the eleven states that will be participating in the Migrant Health Service Referral System by the close of this project year. It is hoped that this number will be increased during the 1968 project year.

There is definite room for imporvement of existing migrant housing in Florida, despite the fact that many units were renovated or replaced by new ones this year. It is anticipated that the pace of improvements in housing will accelerate during the remainder of the year and continue during the coming year. There is a difference of opinion among migrants as to the position that Florida housing holds when compared with that provided in other states. Certainly the magnitude of agriculture (fruit and vegetables) in the state merits greater attention to adequate migrant housing by growers, landlords, and sanitarians alike than has been demonstrated in the past. There are four vacancies for sanitarians on the project at present, but it is hoped that these will be filled in the near future and that this will "shore up" the migrant sanitation program in five project counties. The employment of four community health workers to fill the present four vacancies in this discipline should also contribute to the upgrading of housing in project counties.

Several project counties are cooperating with local school boards and the State Department of Education in various "Poverty" programs directed toward migrant children and adults. This cooperation will continue through this year. Some of the programs under the aegis of the Office of Economic Opportunity which have involved project personnel have been of benefit to the migrants. Those involving migrant health aspects have been most successful when they depended upon professional public health personnel for advice, guidance, and/or direction.

Two-hundred and ninety-two cases of primary and secondary syphilis were identified among migrants in 1965, a case rate of 292.0 per 100,000 as compared to a case rate of 40.6 among the general Florida population for the same year. It is estimated by venereal disease control officials that the cases of primary and secondary syphilis among Florida migrants during the fiscal year 1966-67 will exceed 390.0 per 100,000 - an alarming increase. These figures clearly demonstrate the need for special control measures. An application has been submitted by the Florida State Board of Health to the United States Public Health Service for funds to finance a project to be titled Migrant Syphilis Casefinding Demonstration Project. This project was developed in order to demonstrate an intensive syphilis casefinding program among the 100,000 migrant farm laborers passing through Florida. Four public health advisors (or health field workers) and one coordinator will be assigned to this project to go into major migrant areas of the state. They will carry out an organized plan of operation designed to identify the syphilis-prone population in these migrant areas. This will be done by selective bloodtesting, complete and rapid casefinding, and education.

The project will be administered by the Venereal Disease Program of the Bureau of Preventable Diseases. It is planned to begin the project in June, if the application is acted upon favorably. Migrant project personnel will lend all assistance possible and migrant clinic facilities will be used where and when needed.

The inservice training program for project personnel has been of evincible value in the past and will be continued. This program includes visits by personnel to project counties other than their own to observe ongoing project services and techniques, attendance at meetings around the state sponsored by organizations interested in the migrants' welfare, and the holding of an annual Migrant Health Conference.

The second annual Florida Migrant Health Conference was held at Miami Beach from December 7 - 9, 1966. Registration totaled 172, with 12 persons attending from out of state. Some of the program topics were:

- "The Union and Florida's Migrants"
- "Environmental Safety for Migrants"
- "Problems Involved in Migrant Health Service Continuity" (Panel Discussion)
- "A Nutrition Program for Florida's Migrants"
- "Welfare's Role in Migrant Care"
- "Projected Federal Programs for Migrants" (Panel Discussion)
  - "New Programs in Education for Migrant Children"
  - "New OEO Programs for Migrants"
  - "New Community Action Fund Programs for Migrants"
- "Communicable Diseases in the Migrant Population"

"Tuberculosis"
    "Venereal Disease"
"Annual Reports and the Revision of the Reporting Kit"
"Cultural Implications in Planning Health Programs" (Panel Discussion)
    "Negro Culture"
    "Mexican Culture"
    "Puerto Rican Culture"
"Dental Programs for Migrants"
"Importance and Techniques of Public Relations"
"Health Education in the Migrant Program"

It is planned to hold another annual conference financed by project funds this fall. These meetings are held for the purposes of keeping project personnel abreast of latest developments in the field of migrant health, to give them background information on the mores of the migrant population, and to promote among the personnel an interchange of dialogue concerned with migrant problems and possible problem solutions. The concensus of those attending the conference last year was that it was both interesting and informative and should be held again in 1967.

The United States Public Health Service extended the 1965 grant period for an additional month (through January, 1966) and extended the 1966 grant period for two additional months (through February, 1967). These two extensions wrought havoc with the project bookkeeping systems kept by the participating counties and the Migrant Health Coordinator's office. It is proposed and planned that in the future the calendar year be adhered to as the grant period to assure that confusion in project bookkeeping and accounting be held to a minimum.

PROJECT OBJECTIVES FOR 1968

I. TO CONTINUE TO INCREASE MEDICAL SERVICES RENDERED TO THE MIGRANT POPULATION:

(a) By the inauguration of additional clinics, where feasible.

(b) By increasing the number of migrant attendees at existing and new clinics.

(c) By increasing the number of patient referrals to physicians on a fee-for-service basis in those counties not operating migrant medical clinics.

II. TO CONTINUE TO INCREASE DENTAL SERVICES RENDERED TO THE MIGRANT POPULATION:

(a) By rendering more comprehensive dental care rather than limiting care to cases of an emergency nature as in the past.

(b) By increasing the number of migrant attendees at existing dental clinics.

(c) By increasing the number of patient referrals to dentists on a fee-for-service basis in those counties not operating migrant dental clinics.

III. TO INCREASE THE NUMBER OF COUNTIES PARTICIPATING IN THE MIGRANT PROJECT.

IV. TO ASSURE THAT THE GRANT PERIOD FOR THE COMING YEAR WILL BEGIN ON JANUARY 1, 1968, AND END ON DECEMBER 31, 1968.

Project Grant Number: MG-18D (67)

Project Title: A Project to Develop a Statewide Program of Health Services for Migrant Farm Workers and their Dependents in Florida

Period Covered: May 1, 1966, through April 30, 1967

SUMMARY

The fourth year or grant period of the Florida Migrant Health Project began in March, 1967, with sixteen (16) county health departments participating and ends on the last day of this year. The period covered in this Annual Progress Report extends from May 1, 1966, through April 30, 1967. During this period there was an appreciable increase in the amount and variety of health services rendered, number of migrants contacted, and activities performed by project personnel.

Migrant workers began arriving during August, 1966, and the employment peak was reached in late January, 1967, with an estimated 79,856 workers. Approximately 8,400 of the 9,600 sugarcane workers were from the British West Indies. The ethnic composition of the "domestics" was estimated to be: Anglo, 17 per cent; Texas-Mexican, 15 per cent; Negro, 58 per cent; Puerto Rican, 10 per cent. There was a decrease in the number of Anglos this year over last. Mechanization in vegetable harvesting increased during the 1966-1967 season but it is expected that the number of workers needed for the 1967-1968 season will not lessen. It is expected that around 40,000 to 45,000 workers and their dependents will "follow the stream" beginning in May, 1967.

There was an increase of 1,222 Migrant Health Service Referrals during this report period over the same period last year. Plans are being finalized to update the existing Health Service Indexes of the present ten participating states; to incorporate the ten indexes into one volume; and to print new and more complete Referral Forms to supplant the present form. The number of participating states will shortly be increased to eleven, with the inclusion of West Virginia.

Project objectives were substantially achieved during the present report period. The number and variety of medical clinics increased, with a consequent increase in the number of migrant patients receiving comprehensive medical care in clinics. There was an upsurge in the number of patients referred to specialists and physicians on a fee-for-service basis in those counties without migrant clinics. There was a noticeable increase in the number of migrants receiving dental care, both in migrant dental clinics and in dentists' offices. Plans previously formulated to carry on programs of vision, dental, and diabetes screening were implemented - resulting in useful data being procured and additional services being rendered to those screened. Nursing services were intensified, especially in the field of follow-up visits. Additional nursing clinics were initiated and more patients were contacted by project nurses.

Due to the lack of qualified sanitarians, several project sanitarian positions

remain unfilled to the detriment of the sanitation aspect of the overall project. There have been advances made toward improved housing for migrants in those counties staffed by project sanitarians, but much remains to be done.

Health education activities were increased in many of the counties and there was an increase in the amount of information regarding the Migrant Project disseminated to the public via communication media and speeches by project personnel. With the employment of a health educator on the project in the near future, health education for migrants and project publicity should both expand.

Plans for the future call for active project cooperation with a proposed intensified venereal disease program to begin this summer; launching of Inpatient Hospital Care this summer; resumption of vision, dental, and diabetes screening in the fall; the activation of additional medical and dental clinics by year's end; and the holding of a Migrant Health Conference this fall.

Project objectives for 1968 include increasing medical and dental services in present project counties and increasing the number of counties participating in the project. It is hoped that the 1968 objectives are obtained with the same degree of success as were those of 1967.